No. 00-1471-CFX Title: Kentucky Association of Health Plans, Inc., et al., Petitioners
v.
Janie A. Miller, Commissioner, Kentucky Department of Insurance

Docketed:
March 22, 2001

Court: United States Court of Appeals for the Sixth Circuit

Entry	Date	Proceedings and Orders
	Feb 8 2001	Application (00A692) to extend the time to file a petition for a writ of certiorari from February 18, 2001 to March 22, 2001, submitted to Justice Stevens.
	Feb 12 2001	Application (00A692) granted by Justice Stevens extending the time to file until March 22, 2001.
	Mar 22 2001	Petition for writ of certiorari filed. (Response due May 21, 2001)
	Apr 13 2001	Order extending time to file response to petition until May 21, 2001.
	May 17 2001	Brief of respondent Jean Miller, Commissioner, Kentucky Dept. of Insurance in opposition filed.
	May 31 2001	Reply brief of petitioners Kentucky Association of Health Plans, Inc., et al. filed.
	Jun 5 2001	REDISTRIBUTED for Conference of June 21, 2001
	Jun 25 2001	The Solicitor General is invited to file a brief in this case expressing the views of the United States.
	Nov 7 2001	Brief amicus curiae of United States filed.
	Nov 14 2001	REDISTRIBUTED for Conference of November 30, 2001
	Jun 20 2002	REDISTRIBUTED for Conference of June 20, 2002
	Jun 24 2002	REDISTRIBUTED for Conference of June 27, 2002
	Jun 24 2002	Supplemental brief of petitioners filed. VIDED.
	Jun 28 2002	Petition GRANTED. SET FOR ARGUMENT January 14, 2003. **********
	Jul 22 2002	Order extending time to file the joint appendix and petitioners' brief on the merits to and including September11, 2002.
	Aug 26 2002	Consent to filing of amicus briefs in support of either party or neither party received from counsel for the petitioners.
	Aug 28 2002	Consent to the filing of amicus briefs in support of either party or neither party received from counsel for the respondents
	Sep 11 2002	Joint appendix filed.
	Sep 11 2002	Brief of petitioners Kentucky Association of Health Plans, Inc., et al. filed.
	Sep 11 2002	Brief amici curiae of American Association of Health Plans, Inc., et al. filed.
	Sep 11 2002	Brief amicus curiae of Society for Human Resource Management filed.
	Sep 11 2002	Brief amici curiae of Community Health Partners and Resevoir Park Health filed.
	Sep 22 2002	Order extending time to file respondent's brief on the merits to and including October 31, 2002.

No. 00-1471-CFX

Entry	Date	Proceedings and Orders
	Oct 31 2002	Brief of respondent Janie Miller, Commissioner of KY Department of Insurance filed.
	Oct 31 2002	Brief amicus curiae of American College of Legal Medicine filed.
	Oct 31 2002	Brief amicus curiae of United States filed.
	Oct 31 2002	Brief amici curiae of American Medical Association, et al. filed.
	Oct 31 2002	Brief amici curiae of Texas, et al. filed.
	Oct 31 2002	Brief amici curiae of Council of State Governments, et al. filed.
	Nov 14 2002	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed.
	Nov 18 2002	Application (02A402) to extend the time to file a reply brief from December 2, 2002 to December 9, 2002, submitted to Justice Stevens.
	Nov 18 2002	Motion of American Medical Association for leave to participate in oral argument as amicus curiae and for divided argument filed.
	Nov 19 2002	Application (02A402) granted by Justice Stevens extending the time to file until December 9, 2002.
	Dec 7 2002	CIRCULATED.
	Dec 9 2002	Reply brief of petitioners Kentucky Association of Health Plans, Inc., et al. filed.
	Dec 10 2002	Record filed.
	Dec 16 2002	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED.
	Dec 16 2002	Motion of American Medical Association for leave to participate in oral argument as amicus curiae and for divided argument DENIED.
	Jan 14 2003	ARGUED.

(1)

Supreme Court, U.S.
FILED

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No. 00-____

IN THE

Supreme Court of the United States

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., *et al.*,
Petitioners,

v.

JANIE MILLER, COMMISSIONER OF THE KENTUCKY DEPARTMENT OF INSURANCE,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

PETITION FOR A WRIT OF CERTIORARI

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123 pp

QUESTION PRESENTED

ERISA preempts any state law that "relates to" ERISA-covered employee benefit plans, unless the law is within the statute's insurance "saving" clause, which saves from preemption any state law "which regulates insurance." Petitioners include health maintenance organizations ("HMOs") that make limited-size networks of health care providers available to ERISA health benefit plans. Kentucky's "Any Willing Provider" ("AWP") statutes, however, require HMOs to open their networks to *any* provider in the geographical area willing to meet the network contract terms. The Sixth Circuit below unanimously held that Kentucky's AWP statutes relate to ERISA-covered benefit plans, but by a 2-1 decision joined the Fourth Circuit in holding that AWP statutes are not preempted by ERISA because they are laws "which regulate[] insurance," rejecting contrary decisions of the Eighth and Fifth Circuits.

The following question is presented:

Are state "Any Willing Provider" statutes preempted by ERISA, or are they saved from preemption because they are laws "which regulate insurance"?

PARTIES

Petitioners are the Kentucky Association of Health Plans, Inc.; Aetna Health Plans of Ohio, Inc.; Choicecare Health Plans, Inc.; HMPK, Inc.; HPLAN, Inc.; and Humana Health Plan, Inc., all of which were plaintiffs in the district court and appellants in the court of appeals.

Advantage Care, Inc., and FHP of Ohio, Inc., also plaintiffs-appellants below, are no longer parties to this action and are not petitioners in this Court.

Respondent Janie Miller succeeded to the position of Kentucky Commissioner of Insurance after the court of appeals entered judgment in this case, and is accordingly substituted as respondent pursuant to Sup. Ct. R. 35.3.

CORPORATE DISCLOSURE

Petitioner Kentucky Association of Health Plans, Inc., is a nonprofit corporation with no parent corporation. Aetna, Inc., is the parent corporation of petitioner Aetna Health Plans of Ohio, Inc. Humana, Inc., is the parent corporation of petitioners Choicecare Health Plans, Inc.; HMPK, Inc.; HPLAN, Inc.; and Humana Health Plan, Inc.

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PETITION FOR A WRIT OF CERTIORARI

Petitioners Kentucky Association of Health Plans, Inc., *et al.*, respectfully pray that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Sixth Circuit in this case.

OPINIONS BELOW

The opinion of the Sixth Circuit is published at 227 F.3d 352 (6th Cir. 2000), and is reprinted in the appendix to this petition ("App.") at 1a. The opinion of the United States District Court for the Eastern District of Kentucky is unpublished and is reprinted at App. 64a. The district court's order of final judgment is unpublished and is reprinted at App. 86a.

STATUTORY PROVISIONS INVOLVED

The relevant provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001, *et seq.*, are reprinted at App. 88a. The Kentucky Any Willing Provider statutes at issue in this case are reprinted at App. 89a-91a.

JURISDICTION

The opinion and judgment of the court of appeals was entered September 7, 2000. A timely petition for rehearing and suggestion of rehearing en banc was denied by order entered November 20, 2001. App. 87a. On February 12, 2001, Justice Stevens extended the time for filing this petition to March 22, 2001. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATEMENT OF THE CASE

Petitioners are five health maintenance organizations ("HMOs") and a Kentucky-based association of HMOs. As one means of controlling the cost and quality of health-care delivery, petitioners and other HMOs have contracted with

selectively-chosen doctors, hospitals, and other health care providers to create exclusive "provider networks." These "participating providers" are required by their contracts to provide health care services to the HMOs' subscribers at discounted rates and to comply with other contractual requirements. In exchange for their rate discount, participating providers receive the advantage of access to the HMOs' subscribers and, consequently, increased patient volume over non-network providers who lack such access. The value of network membership (and, accordingly, the amount providers will agree to discount their services) depends crucially on the HMOs' ability to limit the number of providers in the network; the fewer the providers, the greater the patient volume for each provider.

Petitioner HMOs make their provider networks available to ERISA-governed employee health benefit plans in two different ways. First, several HMOs contract with ERISA plans to enroll plan beneficiaries as direct subscribers in the HMO. Second, several HMOs make their provider networks available to self-funded employee plans (that is, plans in which benefits are paid for by the employer, rather than the HMO), for which the HMOs provide only administrative services.

The question presented in this case is whether ERISA allows states to enforce laws – called "Any Willing Provider" ("AWP") laws – prohibiting HMOs from limiting the size of the provider networks they make available to ERISA-governed plans and their beneficiaries. A Sixth Circuit panel held below that such laws would appear to be preempted by ERISA in that they "relate to" ERISA plans, but further held – over the dissent of Judge Kennedy – that AWP statutes are laws "which regulate insurance" and therefore are "saved" from preemption by ERISA's insurance-law "saving" clause. The majority's decision exacerbates conflicts in the federal circuits not only over the ultimate question whether AWP

statutes are laws "which regulate insurance" and thus saved from ERISA preemption, but also over a fundamental underlying legal principle that governs that question. The decision below also conflicts with a key precedent of this Court defining the business of insurance. The Court should grant review to resolve the critically important question this case presents.

A. Statutory Background

1. *ERISA Preemption and "Saving" Clause.* As a general matter, ERISA broadly preempts any state law that "relates to" an ERISA-governed employee benefit plan. 29 U.S.C. § 1144(a). Congress, however, chose to save out from ERISA's preemptive force any state law "which regulates insurance." *Id.* § 1144(b)(2)(A). In other words, even if a law otherwise "relates to" an ERISA plan, it is not preempted if it can be understood as a law "which regulates insurance." In ERISA's so-called "deemer" clause, however, Congress further declared that employee benefit plans themselves could not be deemed to be insurance or an insurance company for purposes of the saving clause. *Id.* § 1144(b)(2)(B).

This Court's precedents have erected a "framework for resolving whether a state law 'regulates insurance' within the meaning of the saving clause." *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 367 (1999):

> First we ask whether from a "common sense view of the matter," the contested prescription regulates insurance. Second, we consider three factors employed to determine whether the regulation fits within the "business of insurance" as that phrase is used in the McCarran-Ferguson Act: "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry."

Id. (citations omitted); *see Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48-49 (1987).

2. *Kentucky's "Any Willing Provider" Laws.* The Kentucky Legislature enacted the state Health Care Reform Act in 1994. That Act included a general AWP provision, which in its current form provides:

> A health insurer shall not discriminate against any provider who is located within the geographical coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer . . . .

Ky. Rev. Stat. § 304.17A-270. The Act further defines the "insurers" covered by this law as

> any insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to do transact health insurance business in Kentucky.

Ky. Rev. Stat. § 304.17A-005(23).[1] In addition to this general AWP law, in 1996 the Legislature added another AWP provision specifically addressed to contracts between health benefit plans – including HMOs – and chiropractors. *See id.*

[1] The general AWP provision was codified at Ky. Rev. Stat. § 304.17A-110(3) when the complaint in this case was filed. At that time the law applied to "health benefit plans." The legislature subsequently recodified the law at § 304.17A-270, and changed the term "health benefit plans" in the provision to "health insurers," adding a definition of "health insurers" in § 304.17A-005(23). The court below addressed the current language of the statute, agreeing with both parties below that the textual alteration and recodification of this AWP provision did not render the challenge to the AWP laws moot. App. 6a, 40a n.1.

§ 304.17A-171(2). The chiropractic AWP statute does not differ in substance from the general AWP law.[2]

The purpose and effect of the AWP laws is to require petitioners and other HMOs to throw open their closed provider networks to any provider in the geographic area willing to abide by the contract terms. Because HMOs' ability to control costs depends in large part on their ability to control the number of providers with network access, as discussed above, *see supra* at 2, the unavoidable consequence of the law is to drive up the costs of the health care services offered by HMOs through provider networks. And HMOs, unable to restrict their networks to providers of their own careful selection, are also less able to regulate and control the quality of care offered by network providers.

B. Proceedings

1. Petitioners filed a complaint in April 1997 in the United States District Court for the Eastern District of Kentucky against the Commissioner of the Kentucky Department of Insurance seeking, *inter alia*, declaratory judgment that Kentucky's AWP laws are preempted by ERISA. The parties cross-moved for summary judgment on the ERISA preemption count. The district court entered an order declaring the challenged laws valid, thus denying petitioners' motion for summary judgment and granting respondent's cross-motion. The court granted petitioners' motion for partial final judgment under Rule 54(b), and entered an order of final

[2] The same Act that established the chiropractic AWP law also included other restrictions on petitioners' freedom to contract with chiropractors. *See* Ky. Rev. Stat. § 304.17A-171(1) & (3)-(8). The court below remanded the issue of whether those provisions are preempted by ERISA. App. 4a n.3. This petition does not raise any preemption question in respect to the remanded provisions of the chiropractic law.

judgment on the ERISA preemption count on September 22, 1998.[3] Petitioners appealed to the Sixth Circuit.

A separate suit challenging Kentucky's AWP laws was filed in December 1996 in the Western District of Kentucky by Community Health Partners, Inc. Judgment was entered in that suit on June 11, 1998, and the plaintiff in that suit also appealed.

2. The instant case and the *Community Health Partners* case were assigned to the same Sixth Circuit panel, which heard argument separately in the two cases. The court issued full majority and dissenting opinions only in this case, however, and incorporated those opinions into its *Community Health Partners* decision.[4]

(a) The panel unanimously agreed that Kentucky's AWP laws "relate to" ERISA plans. App. 7a-19a (majority, per Holschuh, D.J., sitting by designation); *id.* at 39a (Kennedy, J., dissenting). But the majority concluded that those laws are saved from preemption under ERISA's saving clause because they are "laws which regulate insurance."

i. Starting with the "common sense" prong of the insurance saving clause test, the majority focused primarily on the fact that Kentucky's AWP laws apply in terms to "insurers." App. 24a-25a. On that basis alone the court determined that the "Kentucky AWP laws are thus specifically directed toward insurers and the insurance industry and are ones that from a 'common sense view' regulate insurance." App. 25a. Adding further that the AWP laws also "deal directly with the relationship between insurers and insureds under health benefit plans," and "are part of a comprehensive subtitle of

[3] The other counts, which seek declaratory judgment and injunctive relief from the Kentucky AWP laws on other statutory and constitutional theories, remain pending in the district court.

[4] A petition for certiorari was filed in *Community Health Partners* ("*CHP* Pet."), No. 00-1295, 69 U.S.L.W. 3557, on February 12, 2001.

Kentucky's insurance code regulating health benefit plans," the court concluded that for those reasons as well the AWP laws are "clearly laws which, in a common sense view of the matter, 'regulate insurance.'" App. 30a.

In reaching that determination, the panel majority rejected the argument that the AWP laws do not regulate insurance because they apply in fact not just to "insurers" as traditionally understood, but also to employers that pay directly for their employees' health services, to HMOs that provide care rather than indemnification, and to HMOs that act solely as plan administrators and thus provide no benefits to insureds at all. As to the statutes' application to employers, the court concluded that self-funded employers' plans involve "the business of insurance." App. 26a. The court brushed aside ERISA's "deemer clause" – which explicitly prohibits states from deeming self-funded plans to be "insurance" for purposes of the saving clause, *see* 29 U.S.C. § 1104(b)(2)(B) – on the unelaborated ground that the statutory distinction between "insurance" and a self-funded employer plan "is not a distinction based upon a concept that employers who choose to be self-insurers cannot be considered insurers subject to state regulations dealing with insurance." App. 26a. In so holding, the court acknowledged but expressly rejected the contrary conclusion of the Eighth Circuit in *Prudential Insurance Co. of America v. National Park Medical Center*, 154 F.3d 812, 829 (8th Cir. 1998). App. 27a.

As to the laws' application to the two functions HMOs – including petitioners – serve in relation to employee health plans, *see supra* at 2, the court first concluded that HMOs that directly provide medical benefits, while not traditional insurers, "'[i]n the end . . . function the same way as a traditional health insurer.'" App. 23a (quoting *Washington Physician Serv. Ass'n v. Gregoire*, 147 F.3d 1039, 1056 (9th Cir. 1998), *cert. denied*, 525 U.S. 1141 (1999)). And in respect

to HMOs that provide solely administrative services, the court simply construed the statute as excluding HMOs serving only that function for ERISA plans, App. 26a, 28a n.14, even though both AWP laws specifically include all HMOs within their sweep and neither distinguishes among the services HMOs provide. Despite the fact that even under the court's construction the Kentucky AWP laws apply to HMOs that provide solely administrative services to non-ERISA self-funded plans, the court concluded that the AWP laws are "limited to health care 'insurers.'" App. 28a.

ii. The panel majority then turned to the three McCarran-Ferguson factors. The court found the first – whether the law affects the transfer or spreading of the risk against which the policyholder is insured – to be "certainly a debatable issue," App. 30a, but found it satisfied simply because AWP laws allow insureds to receive covered services from providers for whose services insureds would otherwise have to pay directly. Following an earlier decision of the Fourth Circuit upholding an AWP law against preemption challenge, the panel majority reasoned that AWP laws spread the "cost component" of the policyholder's risk among all insureds, in that the policyholder is not required to shoulder all the cost when seeking care from a provider outside the network. App. 31a (quoting *Stuart Circle Hosp. Corp. v. Aetna Health Mgmt.*, 995 F.2d 500, 503 (4th Cir.), *cert. denied*, 510 U.S. 1003 (1993)).

As to the second McCarran-Ferguson factor, the court held that AWP laws govern a practice that is an "integral part of the policy relationship between the insurer and the insured," App. 35a, even while acknowledging that "it is admittedly true that the AWP laws do not change the substantive terms of the insurance coverage." App. 36a. The court considered the mandatory change "from a closed pool of providers to an open pool of providers" to be the same as "expanding covered treatment." *Id.*

Finally, bootstrapping its earlier analysis of the laws' application to HMOs and self-funded employer plans under the common-sense prong, the majority concluded that the Kentucky AWP laws are limited to entities within the insurance industry, and thus that the third McCarran-Ferguson factor is satisfied as well. App. 36a.

(b) Judge Kennedy dissented, rejecting the majority's conclusions at every step of the saving clause analysis. She first concluded that "the Kentucky AWP laws do not meet the common sense test because they are directed at the contracts between benefit plans and third parties, rather than being specifically directed at the insurance industry." App. 40a. And as applied to HMOs whose only duty is administration, Judge Kennedy reasoned, the AWP laws are "not directed at the business of insurance, as no insurance is involved." App. 43a. In Judge Kennedy's view,

> The common sense conclusion that can be drawn from the AWP statute's coverage of entities clearly operating outside of the business of insurance is that the statute is concerned generally with regulating provider access to networks rather than specifically regulating the business of insurance.

App. 44a.

Judge Kennedy found the majority's treatment of the McCarran-Ferguson factors equally uncompelling. Labeling the "cost component" risk-spreading theory relied upon by the majority as "attenuated," App. 55a, Judge Kennedy observed that "[t]he critical issue with respect to the risk-spreading prong . . . is whether or not the law is related to *the risks underwritten by the insurer*." App. 54a (emphasis added). Health insurance policies underwrite only "the risk that [the] insured will need medical treatment for a condition covered under the policy," App. 56a, and under Kentucky's AWP laws, Judge Kennedy explained, "[t]here is no shifting of [that] risk," *id.*; *see* App. 54a (AWP laws merely "dic-

tat[e] how [insurers] structure their provider networks, irrespective of the risks they underwrite").

As to whether the AWP laws are integral to the insured-insurer relationship, Judge Kennedy considered the matter quite clear:

> Kentucky's AWP provisions leave the contract terms between the insurer and insured[] unaltered. The relationships directly affected by the law are those existing between insurers and third parties (*i.e.*, medical providers). . . . [T]he medical risks covered by the policy remain the same. Thus, even if an insured's preferred provider decides to join the insured's network, and complies with its terms in doing so, the medical coverage that the insurer has contracted to underwrite remains unchanged. . . . Kentucky's AWP laws do not force the insurer to offer a benefit to insureds that was not available before the law.

App. 59a. Finally, also bootstrapping her discussion under the common-sense prong, Judge Kennedy concluded that the AWP laws satisfy the third McCarran-Ferguson factor because they "extend[] to include entities in no way involved in underwriting risks." App. 60a.

REASONS FOR GRANTING THE WRIT

The Court should grant review of this case to resolve a split in the federal circuits, exacerbated by the decision below, over a question of acute importance to health care regulation policy across the Nation, *viz.*, whether states may continue to enact and enforce "Any Willing Provider" restrictions on the ability of health insurers, HMOs, and employers to limit the number of health care providers with whom they contract to provide health care services to employee health

benefit plan beneficiaries.[5] In the face of lawsuits asserting that such laws are preempted by ERISA, the Sixth Circuit in this case and the Fourth Circuit have upheld AWP laws as within ERISA's insurance "saving clause," *see supra* at 6-9; *Stuart Circle Hosp. Corp. v. Aetna Health Mgmt.*, 995 F.2d 500 (4th Cir.), *cert. denied*, 510 U.S. 1003 (1993); the Eighth and Fifth Circuit have reached the opposite conclusion, *see Prudential Ins. Co. v. National Park Med. Ctr.*, 154 F.3d 812, 829 (8th Cir. 1998); *Texas Pharmacy Ass'n v. Prudential Ins. Co. of Am.*, 105 F.3d 1035 (5th Cir.), *cert. denied*, 522 U.S. 820 (1997); *Cigna Healthplan v. Louisiana*, 82 F.3d 642 (5th Cir.), *cert. denied*, 519 U.S. 964 (1996). Not surprisingly, this difference in outcomes also implicates a division over the nature and content of a key legal principle governing the determination whether a law is one which "regulates insurance," a division that extends even beyond the instant context. That conflict has arisen in part because several courts – including the court below – have failed to adhere faithfully to a precedent of this Court squarely holding that third-party provider contracts of the very kind regulated by AWP laws are *not* the "business of insurance." *See Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). Review should be granted to resolve the conflict between that decision and the decision below as well.

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[5] The manifest importance of the issue presented here is fully and accurately stated in the *Community Health Partners* petition. *CHP* Pet. 1-2, 25-30. We expect respondent will fully agree that the enforceability of state AWP laws is a question of great significance for health-policy regulation in the many states, including Kentucky, that have chosen to enact such laws.

I. THE COURT SHOULD GRANT REVIEW TO RESOLVE CONFLICTS IN THE FEDERAL CIRCUITS OVER WHETHER AWP STATUTES FALL WITHIN ERISA'S SAVING CLAUSE AND OVER PRINCIPLES GOVERNING SAVING CLAUSE ANALYSIS

Review of this case would enable the Court to address at least two important controversies in the federal circuits over issues squarely presented in this case. The first is a direct split in the circuits over whether AWP laws are preempted by ERISA. The second is a disagreement in principle among the circuits over the question whether laws that affect only the so-called "cost component" of insurance risk satisfy the risk-transfer or risk-spreading prong of the McCarran-Ferguson inquiry.

A. There Is A Square Split In The Circuits Over The Question Whether AWP Statutes Are Laws Which Regulate Insurance

The Sixth and Fourth Circuit have each held that AWP statutes are merely "laws which regulate insurance" and thus are not preempted by ERISA. The Eighth and Fifth Circuits have held to the contrary.

1. The Sixth Circuit panel majority opinion in this case determined that the Kentucky AWP statutes are laws which regulate insurance for the reasons discussed above. *See supra* at 6-9. In so holding, the Sixth Circuit followed the Fourth Circuit's opinion in *Stuart Circle*, which held that a similar AWP law "relates to" ERISA employee benefit plans but is saved from preemption because the law "regulates insurance." *See Stuart Circle*, 995 F.2d at 503-04.

Like Kentucky's law, the Virginia statute at issue in *Stuart Circle* prohibited insurers and benefit plan administrators from entering into exclusive contracts with preferred providers. *Id.* at 501. The court held, first, that the statute "regulates insurance" as a matter of "common sense" because it was "part of a comprehensive code regulating accident and sickness insurance," and because it prohibited insurers from unreasonably restricting the insured's choice of provider. *Id.* at 503. Addressing the McCarran-Ferguson factors next, the *Stuart Circle* court found the first satisfied under the "cost component"/risk-spreading theory followed by the Sixth Circuit in this case – *i.e.*, that by opening up provider networks, AWP laws spread among all insureds the risk that one will be subjected to the cost of care from a nonnetwork provider. *Id.* at 503; *see id.* at 504 (statute "affects the risk that an insured must bear" because it affects "the consequent cost to the insured if he or she deems an excluded provider to be better qualified [than any network provider] for treatment of a specific illness or accident"). The court applied the same rationale to the second factor, reasoning that "treatment and cost" are "integral parts of the relationship between insurer and insured," *id.*, and found the third factor – application to entities outside the insurance industry – satisfied, *id.* at 504, even though the statute applied to HMOs and others acting solely as administrators, Va. Code § 38.2-3407(A).

2. In contrast to the Sixth and Fourth Circuits, the Fifth and Eighth Circuits each have held AWP statutes to be preempted because they are *not* laws which regulate insurance.

(a) In *Prudential Insurance*, *supra*, the Eighth Circuit considered an Arkansas AWP statute that is "almost identical" to Kentucky's, *Ward v. Alternative Health Delivery Sys.*, 55 F. Supp. 2d 694, 701 (W.D. Ky. 1999), but the Eighth Circuit held that the Arkansas law fails both the common sense test and all three McCarran-Ferguson factors, and therefore is not saved from preemption by ERISA.

Applying the common-sense test, the Eighth Circuit found "unpersuasive" the fact that Arkansas' AWP law is "codified as part of the Arkansas insurance code." *Prudential Insurance*, 154 F.3d at 829; *contra* App. 30a (Kentucky

AWP laws satisfy common-sense test in part because they "are part of a comprehensive subtitle of Kentucky's insurance code regulating health benefit plans"); *Stuart Circle*, 995 F.2d at 503 (Virginia AWP law satisfies test in part because it is part of "part of a comprehensive code regulating accident and sickness insurance"). What matters, the court explained, is that the law in fact regulates "far more than just insurance or the insurance industry." *Prudential Insurance*, 154 F.3d at 829. Just as the dissent below argued in respect to Kentucky's law, *see supra* at 9 (quoting App. 44a), the Eighth Circuit reasoned:

> An act that purports to regulate 'health benefit plans' defined so broadly as to include employers and administrators of self-insured plans, as well as traditional insurance, simply does not fit within a common-sense view of a law directed specifically toward the insurance industry.

154 F.3d at 829.

The Eighth Circuit also held that the Arkansas AWP law fails each prong of the McCarran-Ferguson inquiry. In contrast to the "cost component"/risk-spreading theory adopted by the Fourth and Sixth Circuits, the Eighth Circuit held that the AWP law "plainly does not have the effect of transferring or spreading the policyholder's risk." *Id.* Nor, the court explained, is the law integral to the insured-insurer relationship; it affects "only the terms of the relationship between the insurer and a third party, and hence is 'no more "integral" to the insurer-insured relationship' than any contract an insurer might make with any other third party." *Id.* at 830 (quoting *Pilot Life*, 481 U.S. at 50-51); *contra* App. 36a (finding Kentucky AWP laws integral to insurer-insured relationship even though they "do not change the substantive terms of the insurance coverage"); *Stuart Circle*, 995 F.2d at 503 (arguing that "treatment and cost" affected by AWP laws are "integral parts of the relationship between insurer

and insured"). Finally, the Eighth Circuit held that the Arkansas law fails the third McCarran-Ferguson factor because it regulates such non-insurance entities as employers, hospitals, and third-party administrators. 154 F.3d at 830.

(b) The decisions of the Fourth and Sixth Circuit conflict with decisions of the Fifth Circuit as well. In *CIGNA Healthplan*, *supra*, the Fifth Circuit held that a Louisiana AWP law was preempted by ERISA, and the court applied that precedent to reach the same conclusion in respect to a Texas AWP law in *Texas Pharmacy*, *supra*. In both cases the court held that the AWP statutes were not "laws which regulate insurance" because the laws were "not limited to entities within the insurance industry." *Texas Pharmacy*, 105 F.3d at 1038; *see CIGNA Healthplan*, 82 F.3d at 650. The Texas statute, the court explained, also applied "to [HMOs], [PPOs], and other organizations that provide health care services." *Texas Pharmacy*, 105 F.3d at 1038. The court noted that the law also applied to "ERISA benefit plans themselves," *id.* at 1038-39, further noting that "[t]he 'deemer provision' of ERISA prohibits treating ERISA employee benefit plans themselves as being engaged in the business of insurance," *id.* at 1039; *contra* App. 26a (ERISA "deemer clause" does not preclude conclusion that self-funded employer plans are "insurance" for purpose of saving clause); *Stuart Circle*, 995 F.2d at 504 (same). Similarly, the Fifth Circuit reasoned that Louisiana's AWP law fell outside the saving clause because it applied not only to insurers, but also "to 'self-funded organizations, Taft-Hartley trusts, or employers who establish or participate in self funded trusts or programs,' as well as 'health care financiers, third party administrators, providers or other intermediaries.'" *CIGNA Healthplan*, 82 F.3d at 650.[6]

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[6] In both *Texas Pharmacy* and *CIGNA Healthplan*, the Fifth Circuit explicitly evaluated only the third McCarran-Ferguson factor. But its conclusion in both cases that the laws fell outside the saving clause test

3. In addition to the conflict among the federal circuits, federal district courts and state courts have also reached conflicting conclusions in respect to the preemption of AWP laws. *Compare, e.g., Hayden v. Blue Cross & Blue Shield*, 843 F. Supp. 1427 (M.D. Ala. 1994) (Alabama law requiring insurers to reimburse nonnetwork nurses preempted) *with Blue Cross & Blue Shield v. St. Mary's Hosp., Inc.*, 426 S.E.2d 117 (Va. 1993) (no preemption of Virginia AWP law); *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 974 F. Supp. 60 (D. Mass. 1997) (no preemption of Massachussetts AWP law); *Witt v. Aetna U.S. Healthcare, Inc.*, 2000 WL 1336491 (D. Me. Sept. 14, 2000) (magistrate op.) (no preemption of Maine AWP law).

4. There are, of course, certain differences in the wording of the various AWP statutes at issue in the decided cases, but the statutes are all essentially the same in operation and effect. Like Kentucky's, they do not alter the terms of insurance contracts, and like Kentucky's, they prohibit not just insurers, but such non-insuring entities as plan administrators and certain self-funding employers from contracting selectively with medical care providers. The question whether such statutes are laws "which regulate insurance" despite such defining features has now been carefully evaluated by

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because they were not limited to the insurance industry would compel the same conclusion under the common-sense prong as well. *See Pilot Life*, 481 U.S. at 50 ("A common-sense view of the word 'regulates' would lead to the conclusion that in order to regulate insurance, a law must . . . be specifically directed toward that industry."). The Fifth Circuit recently confirmed its agreement on this point. *See Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 215 F.3d 526, 538 (5th Cir. 2000) ("The common sense test measures whether the law is specifically directed toward the insurance industry."), *petition for cert. filed*, No. 00-665, 69 U.S.L.W. 3317 (Oct. 24, 2000). *Corporate Health* holds that a state law necessarily falls outside the saving clause if it "cover[s] employers and others not engaged in insurance practices," 215 F.3d at 538, and explicitly reaffirms *Texas Pharmacy* and *CIGNA Healthplan* on that basis, *id.* at 538 & n.51.

four separate federal circuits and numerous other courts. There is no reason to await further development of this issue in the courts. Nobody can dispute that continued uncertainty over the enforceability of AWP laws harms the interests of states, employers, health benefit and service providers, and patients and beneficiaries. The conflict is ripe for resolution by this Court.

B. The Circuits Are Divided Over The Substantive Content Of The McCarran-Ferguson Risk-Spreading Factor

1. As discussed above, both the opinion of the Sixth Circuit in this case, and the Fourth Circuit opinion on which it relies, explicitly turn in part on the view that AWP laws affect the risk-spreading aspect of the insurance relationship. According to these opinions, by requiring managed care entities to open their provider networks to any willing provider, AWP laws "affect[] the risk that an insured must bear" because they remove "the consequent cost to the insured if he or she deems an excluded provider to be better qualified [than any network provider] for treatment of a specific illness or accident." *Stuart Circle*, 995 F.2d at 504.

The Tenth Circuit has adopted the same broad view of risk-spreading in a related context. *See Blue Cross & Blue Shield v. Bell*, 798 F.2d 1331 (10th Cir. 1986). *Bell* held that a Kansas statute requiring insurance companies to pay for the services of certain specified providers (a "mandated-provider" statute) qualifies for ERISA saving clause protection as a law which regulates insurance. Analyzing the risk-spreading component of the McCarran-Ferguson test, the court explained that an insurance policy transfers "the risk that an individual may need [particular] care," and that "[i]mplicit in the coverage of [such] care is the insured's choice of a deliverer of the care." *Id.* at 1335. "The choice of provider," in other words, "does not add to the insured's

coverage but is of the essence of that coverage bargained for as the transferred risk." *Id.*

2. This expansive view of the McCarran-Ferguson risk-spreading factor conflicts with the views of at least three other circuits. In *Cisneros v. UNUM Life Ins. Co.*, 134 F.3d 939 (9th Cir. 1998), *cert. denied*, 526 U.S. 1086 (1999), the Ninth Circuit explained that "the term 'risk' – as used in this factor – refers to the *risk of injury* for which the insurance company contractually agreed to compensate the insured," *id.* at 945-46 (emphasis added). While the California "notice-prejudice" law at issue in that case – prohibiting a denial of benefits for late-filed claims of which the insurer had timely notice, absent prejudice to the insurer – did shift away from the insured the risk of lost coverage for untimely claims, the court held that it failed the McCarran-Ferguson risk-spreading factor because it did not "alter the allocation of risk for which the parties initially contracted, namely the risk of lost income from long-term disability." *Id.* at 946.[7]

The Eleventh Circuit used similar reasoning in *Smith v. Jefferson Pilot Life Ins. Co.*, 14 F.3d 562 (11th Cir. 1994), to hold that a Georgia law requiring written notice of insurance coverage cancellation fails the risk-spreading factor. Like the Ninth, the Eleventh Circuit emphasized that "the risk-spreading principle concerns . . . the risks of injury that the insurance company will bear for the insured." *Id.* at 569.

And, though the Eighth Circuit's opinion finding Arkansas' AWP law outside the saving clause did not address the broad cost-component/risk-spreading theory in terms, its opinion evinces no uncertainty on the matter: the AWP statute "plainly does not have the effect of transferring or spreading the policyholder's risk." *Prudential Insurance*, 154 F.3d at 829.

[7] The Ninth Circuit ultimately held that the notice-prejudice rule nevertheless fell within the saving clause because it satisfied all the other elements of the saving clause inquiry. *See Cisneros*, 134 F.3d at 945-47. This Court affirmed that conclusion in *UNUM*, *see* 526 U.S. at 368-75, but declined to address the Ninth Circuit's risk-spreading analysis, *see id.* at 374.

Review of this case would enable the Court not only to resolve the conflict over the preemption of state AWP laws, but also to provide further guidance as to the nature of the risk-spreading factor so critical to the insurance saving clause inquiry in any context. As cases like *Bell*, *UNUM*, and *Jefferson Pilot* demonstrate, such guidance will help to clarify the resolution of saving clause issues that arise in respect to a variety of state health care regulatory statutes. Review should be granted for that reason as well.

II. THE COURT SHOULD GRANT REVIEW TO RESOLVE A CONFLICT BETWEEN THE DECISION BELOW AND A DECISION OF THIS COURT

As the opinion below candidly acknowledges, the Kentucky AWP laws do not alter any term of any agreement between insurer and insured. App. 36a ("it is admittedly true that the AWP laws do not change the substantive terms of the insurance coverage"). Rather, the only contracts "directly affected by the law[s] are those existing between insurers and third parties (*i.e.*, medical providers)." App. 59a (Kennedy, J., dissenting). Nevertheless the panel majority, like the Fourth Circuit, concluded that AWP laws do regulate "the business of insurance" as that phrased is used in the McCarran-Ferguson Act, 15 U.S.C. § 1012(b).

This Court has already squarely held, however, that agreements between insurers and third-party service providers are *not* "the 'business of insurance'" under McCarran-Ferguson. *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). The decision below directly conflicts with *Royal Drug*.

1. The insurance company in *Royal Drug* provided a $2 prescription drug benefit as part of its plan, and it contracted

with a limited set of pharmacies to provide drugs to beneficiaries at that $2 price. When a nonparticipating pharmacy challenged that arrangement as a violation of the antitrust laws, the insurance company argued that its pharmacy agreements were sheltered from the antitrust laws by the McCarran-Ferguson Act exemption for the "business of insurance." This Court held, however, that contracts between insurers and providers are not the "business of insurance."

The Court's analysis began with the "underwriting or spreading of risk," which, the Court explained, is "an indispensable characteristic of insurance." *Id.* at 212. The pharmacy provider agreements are not the business of insurance because they "do not involve any underwriting or spreading of risk, but are merely arrangements for the purchase of goods and services by [the insurer]." *Id.* at 214. So long as the insurance company's promise to cover the cost of prescription drugs except for the $2 charge is kept, beneficiaries "are basically unconcerned with arrangements made between [the insurer] and participating [providers]." *Id.* The Court also explained that even though the provider agreements reduce the cost of the risk of needing prescription drugs (a cost that is spread among all insureds), that argument "proves too much," *id.* at 216:

> If agreements between an insurer and retail pharmacists are the "business of insurance" because they reduce the insurer's costs, then so are all other agreements insurers may make to keep their costs under control – whether with automobile body repair shops or landlords.

Id. at 232.

2. The decision below cannot be reconciled with *Royal Drug*'s analysis of third-party provider agreements and the "business of insurance." The third-party health care provider contracts at issue here are indistinguishable from the third-party pharmacy provider contracts at issue in *Royal Drug*.

Indeed, the Court explicitly recognized as much in *Royal Drug* itself:

> There is no principled basis upon which a line could rationally be drawn that would extend the McCarran-Ferguson Act exemption only to an insurer's agreement with providers of goods and services to be furnished to its policyholders – *such as agreements with hospitals, doctors, lawyers, and the like.*

Id. at 232 n.40 (emphasis added); *see id.* at 215 (suggesting that it would not be the "business of insurance" if "an insurance company entered into a contract with a large retail drug chain whereby its policyholders could obtain drugs under their policies only from stores operated by this chain"); *cf. id.* at 243 (Brennan, J., dissenting) ("The Court . . . today holds that *no provider agreements* can be considered part of the 'business of insurance.'" (emphasis added)). If an insurer's agreement with an exclusive set of providers to provide services to policyholders is not the "business of insurance," then a law which regulates such an agreement cannot be a law which regulates insurance.

The single distinction suggested by the majority opinion below only confirms the controlling force of *Royal Drug* in this context. According to the Sixth Circuit, the sole difference between the provider agreements in the two cases is that the insurer in *Royal Drug* "did not restrict the number of providers in question." App. 32a. Thus, the majority below reasoned, the "benefit conferred on the insureds by the Kentucky AWP statutes – removal of restrictions on the number of providers – was already present in *Royal Drug*." *Id.* That "distinction" wholly misses the point: if what insurers were doing in *Royal Drug* was *not* the "business of insurance," a law requiring insurers to do exactly what the insurers in *Royal Drug* were doing cannot be a law regulating the "business of insurance." The proper question is simply whether contracts between an insurer and a network of third-party

providers is part of the business of insurance. *Royal Drug* explicitly answers that question no, and that answer must govern here.[8]

3. This Court's opinion in *Royal Drug* also conflicts with the logic of the "cost component"/risk-spreading analysis of third-party provider contracts adopted by the Sixth Circuit in this case, and by the Fourth and Tenth Circuits as well. *See supra* at 17-18. The terms of the provider agreements at issue in *Royal Drug* necessarily limited the size of the provider network, *Royal Drug*, 440 U.S. at 209, which reduced the costs to all insureds in part by shifting to some insureds the cost of obtaining prescription drugs from non-network providers, *id.* at 214, 216. But such cost savings, the Court made clear, "do not involve any underwriting or spreading of *risk*," *id.* at 214 (emphasis added) – *i.e.*, "the risk that policyholders will be unable to pay for prescription drugs during the period of coverage," *id.* at 213. That risk is

[8] The decision below suggests that the *Royal Drug* may not be controlling because in *United States Dep't of Treasury v. Fabe*, 508 U.S. 491 (1993), this Court "distinguished *Royal Drug* on the ground that it was an antitrust law case, and the Court in that case was construing the words, 'the business of insurance' contained in the second clause of § 2(b) of the McCarran-Ferguson Act, the antitrust law exemption," App. 35a, whereas the "first clause, which commits laws 'enacted by any State for the purpose of regulating the business of insurance' to the States is, according to the Supreme Court, 'not so narrowly circumscribed,'" *id.* (quoting *Fabe*, 508 U.S. at 504). But *Fabe*, if anything, only underscores the vitality of the *Royal Drug* analysis. First, *Fabe* itself explicitly reaffirms *Royal Drug*'s holding that "an insurer's agreements with participating pharmacies to provide benefits to policyholders [i]s not part of the business of insurance." *Fabe*, 508 U.S. at 503. Second, the language of ERISA's saving clause does *not* address laws with the "purpose" of regulating insurance – as does the second clause of the McCarran-Ferguson Act at issue in *Fabe* – but instead only those that actually do "regulate insurance." Finally, this Court since *Fabe* has applied the test derived directly from *Royal Drug*'s analysis of the "business of insurance" to determine whether a law is one "which regulates insurance" under ERISA's saving clause. *See UNUM*, 526 U.S. at 367.

entirely unaffected by the provider agreements. Thus, despite the inherent cost-shifting effect of provider agreements, a law regulating such agreements does not regulate the spreading of the risk against which beneficiaries are insured, and therefore does not regulate the business of insurance. *See* App. 56a (Kennedy, J., dissenting) ("The insurance policy and the contingencies it underwrites, *i.e.*, the risk that insured[s] will need medical treatment for a condition covered under the policy, remain the same, regardless of Kentucky's AWP law."); *Express Scripts, Inc. v. Wenzel*, 102 F. Supp. 2d 1135, 1153 (W.D. Mo. 2000) ("The Any Willing Provider statute would . . . have the likely effect of increasing the number of general practitioners from whom the insured could choose. However, even without the statute, the insured would be able to see a general practitioner in the insurance company's network. Thus, in either case, the risk that the insured will need to see a general practitioner is borne by the insurance company. This is why Any Willing Provider statutes do not spread risk.").

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC.; ADVANTAGE CARE, INC.; AETNA HEALTH PLANS OF OHIO, INC.; CHOICECARE HEALTH PLANS, INC.; FHP OF OHIO, INC.; HMPK, INC.; HPLAN, INC.; HUMANA HEALTH PLAN, INC.,
Plaintiffs-Appellants,
v. No. 98-6308

GEORGE NICHOLS, III, in his official capacity as Commissioner of the Kentucky Department of Insurance,
Defendant-Appellee.

Appeal from the United States District Court
for the Eastern District of Kentucky at Frankfort.
Nos. 97-00024-Joseph M. Hood, District Judge.

Argued: September 20, 1999

Decided and Filed: September 7, 2000

Before: KENNEDY and NORRIS, Circuit Judges; HOLSCHUH,* District Judge.

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* Honorable John D. Holschuh, United States District Judge for the Southern District of Ohio, sitting by designation.

COUNSEL

ARGUED: Robert N. Eccles, O'MELVENY & MYERS, Washington, D.C., for Appellants. Shaun T. Orme, KENTUCKY DEPARTMENT OF INSURANCE, Frankfort, Kentucky, for Appellee. **ON BRIEF:** Karen M. Wahle, O'MELVENY & MYERS, Washington, D.C., Barbara Reid Hartung, GREENEBAUM, DOLL & MCDONALD, Louisville, Kentucky, for Appellants. Shaun T. Orme, Anna R. Gwinn, KENTUCKY DEPARTMENT OF INSURANCE, Frankfort, Kentucky, for Appellee.

HOLSCHUH, D.J., delivered the opinion of the court, in which NORRIS, J., joined. KENNEDY, J. (pp. 38-61), delivered a separate dissenting opinion with respect to Part III of the majority opinion.

OPINION

HOLSCHUH, District Judge. Plaintiffs are seven health maintenance organizations (HMOs) licensed under the laws of Kentucky, and the Kentucky Association of Health Plans, Inc., a non-profit association organized to promote the business interest of its HMO members (hereinafter referred to as "plaintiffs"). Plaintiffs filed this action against George Nichols III ("defendant"), in his official capacity as Commissioner of the Kentucky Department of Insurance. Plaintiffs argued that Kentucky Revised Statutes Annotated §§ 304.17A-110(3) and 304.17A-171(1)-(8) (Banks-Baldwin 1995), should be found preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), and sought injunctive relief from their enforcement. Both parties moved for summary judgment. The district court denied plaintiffs' request for summary judgment and granted defendant's cross-motion for summary judgment, concluding that §§

304.17A-110(3) and 304.17A-171(2) were saved from preemption by ERISA because they "regulated insurance" under ERISA's savings clause. Plaintiffs assert that the district court erred in this conclusion.

I. The State Statutes

In 1994, the Kentucky General Assembly enacted the Kentucky Health Care Reform Act (the "Act"). The Act contained an "Any Willing Provider" provision that stated: "Health care benefit plans shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and is willing to meet the terms and conditions for participation established by the health benefit plan." Ky. Rev. Stat. Ann. § 304.17A-110(3) (Banks-Baldwin 1995). The Act defined a health benefit plan as:

> [Any] hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; and standard and supplemental health benefit plan as established in KRS 304.17A-160. § 304.17A-100(4)(a) (Banks Baldwin 1995).

In 1996, the Kentucky General Assembly added §§ 304.17A-170 and 171 to the code. The additions specifically regulate how "health benefit plans" can interact with chiropractors.[1]

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[1] Section 304.17A-170(1) states that "health benefit plan" has the same meaning as in § 304.17A-005, which provides in pertinent part:

Not only does the statute contain an "any willing provider" provision addressed particularly to chiropractors,[2] but it also imposes various additional requirements on health benefit plans that include chiropractic benefits.[3] See § 304.17A-171.

> "Health benefit plan" means any hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; provider sponsored integrated health delivery network; a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; or any health benefit plan that affects the rights of a Kentucky insured and bears a reasonable relation to Kentucky, whether delivered or issued for delivery in Kentucky . . . .

§ 304.17A-005(17) (Banks Baldwin 1999).

[2] The "any willing provider" provision of § 304.17A-171(2) states: A health benefit plan that includes chiropractic benefits shall:

> (2) Permit any licensed chiropractor who agrees to abide by the terms, conditions, reimbursement rates, and standards of quality of the health benefit plan to serve as a participating primary chiropractic provider to any person covered by the plan.

[3] Specifically, health benefit plans are required to: include all primary chiropractic providers who are selected by a person covered by the plan; allow participants direct access to chiropractors of their choice without referral from a gatekeeper; appoint a chiropractor as a gatekeeper for the provision of chiropractic services when the plan uses gatekeepers; refrain from discriminating in reimbursement rates between chiropractors; refrain from promoting or recommending any chiropractor to a covered person; assure adequate numbers of providers are included in the plan; and make listings of participating chiropractors available to covered persons on a regular basis. § 304.17A-171(1) & (3)-(8).

In April of 1997, plaintiffs filed suit in the Eastern District of Kentucky, requesting that § 304.17A-110(3) and § 304.17A-171 (for convenience we will collectively refer to § 304.17A-110(3) and § 304.17A-171(2) as Kentucky's "AWP" laws) be declared, among other things, preempted by § 514(a) of ERISA, 29 U.S.C. § 1144(a). Plaintiffs moved for partial summary judgment on the issue and Commissioner Nichols cross-moved for partial summary judgment as well. The district court determined that while the Kentucky AWP laws were related to employee benefit plans under ERISA § 514(a), they regulated the business of insurance and therefore fell under the saving clause of § 514(b), 29 U.S.C. § 1144(b)(2)(A). The court thus granted partial summary judgment in favor of Commissioner Nichols and determined its order to be final and appealable. This appeal followed.

Sections 304.17A-110(3) and 304.17A-100(4)(a) were repealed by the Kentucky legislature effective July 1, 1999. The parties acknowledge that this appeal is not moot, however, as the legislature, through House Bill No. 315 (Ky. 1998), replaced the repealed provisions with the same requirements, but substituted the term "health insurer" for "health benefit plan" in its any willing provider provision, now located at Kentucky Revised Statutes Annotated § 304.17A-270 (Banks-Baldwin 1999). The Bill's definition of "insurer" was codified at Kentucky Revised Statutes Annotated § 304.17A-005(22) (Banks-Baldwin 1999), which

The district court apparently limited its analysis to Kentucky's "Any Willing Provider" provisions, the general provision being located at § 304.17A-110(3) and the specific chiropractic provision being located at § 304.17A-171(2). The district court noted that the chiropractic statute imposed additional requirements, beyond those imposed by the general "any willing provider" statute, but because both statutes "similarly define 'health benefit plan'" the court referred to those statutes collectively. J.A. at 35. Because the court never explicitly addressed provisions (1) and (3)-(8) of § 304.17A-171, the chiropractic statute, we will remand the issue of their preemption for consideration in the first instance by the district court.

defines "insurer" as:

> [A]ny insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from-state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky.

The parties having agreed that this appeal is not rendered moot by the new language used in the present statutes, the court will consider the AWP laws in their present form in the court's analysis of their validity, rather than adjudicating the validity of repealed statutes.

The chiropractic provisions contained in § 304.17A-171 and § 304.17A-170 were left intact by House Bill No. 315 and continue to remain unchanged.

The issue of the potential preemption of §§ 304.17A-270 and 304.17A-171(2) by ERISA is therefore properly before this court.[4] We review a district court's decision to grant summary judgment *de novo*, applying the same test as that employed by the district court. *Wathen v. General Elec. Co.*, 115 F.3d 400, 403 (6th Cir. 1997). Summary judgment is proper if there is no genuine issue of material fact and the moving party is entitled to a judgment as a matter of law. *See Schachner v. Blue Cross & Blue Shield of Ohio*, 77 F.3d 889, 892-93 (6th Cir. 1996).

[4] The appeal taken from *Community Health Partners v. Commonwealth of Kentucky*, 14 F. Supp. 2d 991(W.D. Ky.1998), raised the question of whether § 304.17A-110(3) (replaced by § 304.17A-270) was preempted under ERISA and was argued the same day as this case. As a result, this opinion will necessarily dictate the outcome of that case as well.

II. Preemption

We are required by this appeal to define the boundaries of preemption under ERISA § 514 (a) and (b), 29 U.S.C. § 1144(a) and (b). Section 514(a), the preemption provision, reads:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title (emphasis added).

Section 514(b)(2)(A), the "savings" provision, reads:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities.

Section 514(b)(2)(B), the "deemer" provision, reads:

> Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other tnan a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

The federal courts have addressed the scope of ERISA's preemption of State law on numerous occasions; however, the wording of the Act combined with the obvious federalism concerns involved have made it difficult to discern clear

boundaries. Many courts, including the Supreme Court, have commented on the vexingly broad and ambiguous nature of the provisions.[5] Despite such interpretational difficulties, we must determine whether Kentucky Revised Statutes Annotated §§ 304.17A-270 and 304.17A-171(2) (Banks-Baldwin 1999) "relate to" employee benefit plans covered by ERISA. If so, then the provisions are preempted, unless they fall under ERISA's saving clause as laws regulating insurance.

ERISA is a comprehensive act designed to regulate employee welfare and pension benefit plans, including those that provide "'medical, surgical, or hospital care or benefits'" for plan participants or their beneficiaries 'through the purchase of insurance or otherwise.' *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 650-51, 115 S. Ct. 1671, 1674, 131 L. Ed. 2d 695, 702 (1995) (discussing and quoting ERISA § 3(1), 29 U.S.C. § 1002(1)). To assure that the regulation of employee welfare benefits would remain an area of exclusive federal concern, Congress passed § 514(a) of ERISA, the preemption provision.

The Supreme Court has specifically found that in passing

[5] *See, e.g., California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 335-36, 117 S. Ct. 832, 843, 136 L. Ed. 2d 791, 805-06 (1997) (Scalia, J., concurring) (noting that the Court had taken 14 previous cases regarding ERISA preemption, and suggesting that neither the Court's prior decisions, nor its present one, succeeded in bringing clarity to the law); *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656, 115 S. Ct. 1671, 1677, 131 L. Ed. 2d 695, 705 (1995) (remarking on the unhelpful nature of the statute's text and the frustrating difficulty of defining its key terms); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739, 105 S. Ct. 2380, 2389, 85 L. Ed. 2d 728, 740 (1985) (observing that the provisions were "not a model of legislative drafting"); *Prudential Ins. Co. of Am. v. National Park Med. Ctr., Inc.*, 154 F.3d 812, 818 (8th Cir. 1998) (comparing efforts to discern the scope of ERISA preemption to unraveling the fabled Gordian knot).

§ 514(a) it was Congress' intent:

> to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . ., [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.

Travelers, 514 U.S. at 656-57, 115 S. Ct. at 1677, 131 L. Ed. 2d at 706 (alteration in original) (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142, 111 S. Ct. 478, 484, 112 L. Ed. 2d 474, 486 (1990)). In discussing the preemption provision, the Court has variously noted its extreme breadth, terming it "clearly expansive," "broad [in] scope," "broadly worded," "deliberately expansive," and "conspicuous for its breadth." *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, Inc., 519 U.S. 316, 324, 117 S. Ct 832, 837, 136 L. Ed. 2d 791, 799 (1997) (internal citations omitted) (reviewing past Supreme Court case law addressing the scope of ERISA's preemption provision). The preemption provision, however, is not without limits. As the Court noted in *Travelers*, § 514(a) preempts all state laws that relate to an employee benefit plan covered by ERISA, but, "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes preemption would never run its course." 514 U.S. at 655, 115 S. Ct. at 1677, 131 L. Ed. 2d at 705.

Thus, to determine whether a law "relates to" an employee benefit plan, the Court has formulated a two part test, under which a "law 'relate[s] to' a covered employee benefit plan for purposes of § 514(a) if it [1] has a *connection with* or [2] *reference to* such plan." *Dillingham*, 519 U.S. at 324, 117 S. Ct. at 837, 136 L. Ed. 2d at 799 (internal quotations and citations omitted) (emphasis added). The district court

found, and plaintiffs argue, that the Kentucky AWP provisions both refer to and have a connection with ERISA covered employee benefit plans.[6] We analyze each prong of the "relation to" test in turn.

A. Reference To

The Supreme Court has provided guidance in several cases as to when a law "refers to" ERISA. In *Dillingham* the Court summarized its analysis, stating:

> [W]e have held preempted a law that "impos[ed] requirements by reference to [ERISA]," *District of Columbia v. Washington Bd. of Trade*, 506 U.S. 125, 130-31 (1992); a law that specifically exempted ERISA plans from an otherwise generally applicable garnishment provision, *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 828 n.2 (1988); and a common-law cause of action premised on the existence of an ERISA plan, *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140 (1990). Where a State's law acts immediately and exclusively upon ERISA plans, as in *Mackey*, or where the existence of ERISA plans is essential to the law's operation, as in *Greater Washington Bd. of Trade* and *Ingersoll-Rand*, that "reference" will result in preemption.

519 U.S. at 324-25, 117 S. Ct. at 837-38, 136 L. Ed. 2d at

[6] The Western District of Kentucky in *Community Health Partners, Inc. v. Kentucky*, 14 F. Supp. 2d 991, 995-1001 (W.D. Ky. 1998), also found the AWP provisions "related to" ERISA plans, but only under the "connection with" prong of the "relation to" analysis. That court did not believe that the statute referred to ERISA plans in the manner that Supreme Court precedent requires for preemption under the "reference to" prong. Specifically, the court believed that under Dillingham, a law will only "refer to" an ERISA plan for preemption purposes if it "acts immediately and exclusively upon ERISA plans" or "where the existence of ERISA covered plans is essential to the law's operation." *Id.* at 995-96. We disagree with the district court's "reference to" analysis for the reasons set forth in this opinion.

799.

In *Mackey v. Lanier Collection Agency & Service,* Inc., 486 U.S. 825, 108 S. Ct. 2182, 100 L. Ed. 2d 836 (1988), the Court discussed Georgia Code Annotated § 18-4-22.1(1982), which specifically exempted ERISA plans from Georgia's general garnishment law. The Court noted that even though Georgia's legislature may have enacted § 18-4-22.1 to help effectuate ERISA's underlying purpose, it would still be preempted if it fell within ERISA's preemption provision. Finding that § 18-4-22.1 was indeed preempted, the Court stated:

> [A]dhering to our precedents in this area, we hold Ga. Code Ann. § 18-4-22.1, which singles out ERISA employee welfare benefit plans for different treatment under state garnishment procedures, is preempted under § 514(a). The state statute's express reference to ERISA plans suffices to bring it within the federal law's preemptive reach.

Mackey, 486 U.S. at 830, 108 S. Ct. at 2186, 100 L. Ed. 2d at 844. In a footnote, the Court indicated that the "different treatment" was illustrated not just by the express reference to ERISA plans in the statute's language, but also in the disparate treatment accorded to non-ERISA pension and benefit plans under Georgia law. *See id.* at n.4. The effect was that only ERISA welfare benefit plans were singled out for protection under the statute, an impermissible result.

The district court in the case at bar relied on *Mackey* in determining whether Kentucky's AWP statutes referred to an ERISA plan. The district court first observed that under Kentucky's statute, "health benefit plans" were defined to include, among other things, "a self-insured plan or plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA." Based on this language, the court concluded that "it is clear that the AWP statutes 'refer to' ERISA employee benefit plans." In support, the court cited *De Buono v. NYSA-ILA Medical & Clinical Services*

Fund, 520 U.S. 806, 815, 117 S. Ct. 1747, 1752, 138 L. Ed. 2d 21, 30 (1997), which cited *Mackey* for the principle that a provision that explicitly refers to ERISA in defining the scope of the state law's application is preempted.

The district court noted that the Western District of Kentucky in *Community Health Partners, Inc. v. Kentucky*, 14 F. Supp. 2d 991 (W.D. Ky. 1998), disagreed with its analysis of the same statute. The *Community Health Partners* court, relying on language in *Dillingham*, found that Kentucky's AWP statute did not "refer to" an ERISA plan because the law did not act "immediately and exclusively upon ERISA plans" and because the existence of ERISA plans was not essential to the law's operation. *Id.* at 995-96. However, the district court in the present case disagreed with the *Community Health Partners* court, finding that "*Mackey* makes it clear that when a statute 'singles out ERISA employee benefit plans for different treatment' the statute's 'express reference to ERISA plans suffices to bring it within the federal law's preemptive reach.'" J.A. at 12 n.6.

Other courts have reached similar conclusions. The Eighth Circuit in *Prudential Insurance Co. of America v. National Park Medical Center, Inc.*, 154 F.3d 812 (8th Cir. 1998), found that an Arkansas AWP statute containing language comparable to Kentucky's provisions was preempted due to its reference to employee benefit plans covered by ERISA. The court noted that the law expressly stated its provisions "shall not apply to self-funded or other health benefit plans that are exempt from state regulation by virtue of [ERISA]." *Id.* at 822. Accordingly, the court determined that § 23-99-209 of the Arkansas Patient Protection Act ("PPA") referred to ERISA plans, as it "undeniably makes an express reference to ERISA and attempts to exclude from coverage of the PPA at least some ERISA plans. Thus it 'singles out ERISA employee benefit plans for different treatment under state [law], [and therefore] is preempted under § [

1144(a)].'" *Id.* at 824 (quoting *Mackey*). *See also Cigna Health Plan of La., Inc. v. Louisiana*, 82 F.3d 642, 647-48 (5th Cir. 1996) (concluding that Louisiana's AWP statute, § 2202(5)(c) of the State's Health Care Cost Control Act, which applied to "group purchasers," referred to ERISA qualified plans by defining "group purchasers" to include entities such as "'Taft-Hartley trusts or employers who establish or participate in self-funded trusts or programs' which 'contract [with health care providers] for the benefit of their . . . employees.'").

Although in the recent case of *Washington Physicians Service Association v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998), *cert. denied*, *525* U.S. 1141, 119 S. Ct. 1033, 143 L. Ed. 2d 42 (1999), the court found that Washington's "every category of provider" statute did not contain a "reference to" or "connection with" employee benefit plans, the statute at issue is distinguishable from Kentucky's AWP laws. The court noted that by the statute's definition, "health carrier" only included disability insurers, health care service contractors, or health maintenance organizations. *See id.* at 1043. Employer-sponsored, self-funded plans were excluded not by a provision of the act, but rather by limiting the act's application to only the mentioned entities. As a result, the act contained no reference whatsoever to ERISA-covered employee benefit plans.

While a mere reference to an ERISA plan, without more, may not be enough to cause preemption, Supreme Court precedent shows that if such a reference is combined with some effect on those plans, such as singling them out for different treatment, preemption will result. *See, e.g., Mackey*, 486 U.S. at 830 n.4, 108 *S.* Ct. at 2186, 100 L. Ed. 2d at 844; cf. *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 113 S. Ct. 580, 121 L. Ed. 2d 513 (1992) (finding that a state law that imposes requirements merely by reference to ERISA is preempted).

We conclude that Kentucky's AWP statutes "relate to" ERISA plans and are therefore preempted, unless they are found to be statutes that regulate "insurance" under the savings clause of § 514(b)(2)(A). This conclusion also involves consideration of the "deemer" clause, § 514(b) (2)(B), which ensures that ERISA employee benefit plans are not deemed to be engaged in the business of insurance in applying the savings clause. Under the deemer clause, state insurance laws that apply directly to ERISA *self-insured* plans do not fall within the savings clause and thus are preempted. *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 105 S. Ct. 2380, 85 L. Ed. 2d 728 (1985); *FMC Corp. v. Holliday,* 498 U.S. 52, 111 S. Ct. 403, 112 L. Ed. 2d 356 (1990).

The Kentucky legislature, aware of its inability to regulate self-insured ERISA plans, sought to include such plans - as well as multiple employer welfare arrangements (MEWAs) -only "to the extent permitted by ERISA." The effect of this provision is to exclude self-insured ERISA plans from coverage of the statute by virtue of the deemer clause and to include MEWAs only to the extent state regulation is permitted under 29 U.S.C. § 1144(B)(6).[7] In *Community Health Partners v. Commonwealth of Kentucky,* 14 F. Supp. 2d 991 (W.D. Ky. 1998), District Judge McKinley pointed this out in his opinion:

> The fact that the Kentucky legislature chose to allow for regulation of MEWAs and self-insured plans "to the extent permitted by ERISA" suggests that the legislature was well aware of the preemptive force of ERISA. As noted by Defendant, the phrase appears merely to restate the "deemer clause" by exempting self-insured ERISA plans from the scope of the AWP statute. The "deemer clause" prevents a state law

[7] 29 U.S.C. § 1144(B)(6) permits state laws that regulate insurance to apply to MEWAs under the circumstances set forth in that section.

> from "deeming" an employee benefit plan to be an insurance company for the purpose of any law purporting to regulate the business of insurance. 29 U.S.C. 1144 (b)(2)(B). The deemer clause thus effectively prevents states from subjecting self-insured plans to state insurance regulation. On the other hand, insured plans - plans that purchase insurance - are subject to state laws regulating the insurance industry. *See Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 732, 105 S. Ct. 2380, 85 L. Ed. 2d 728 (1985).

Id. at 995 n.4.

As the Supreme Court noted in *UNUM Life Insurance Co. v. Ward, 526 U.S.* 358, 367 n.2, 119 S. Ct. 1380, 1386, 143 L. Ed. 2d 462, 472 (1999):

> Self-insured ERISA plans ... are generally sheltered from state insurance regulation.

The Kentucky Act provides that shelter by its exclusion of ERISA self-insured plans from its coverage, but its reference to ERISA plans and its exclusion of self-insured ERISA plans from its coverage clearly bring the statute within the "refer to" prong of the "relate to" analysis.

B. Connection With

While the fact that the Kentucky statutes "refer to" ERISA employee benefit plans is enough to potentially preempt them on that basis alone, their "connection with" such plans offers an alternative basis for such preemption. Analysis under the "connection with" prong has changed somewhat after the Supreme Court's opinion in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.,* 514 U.S. 645, 115 S. Ct. 1671, 131 L. Ed. 2d 695

(1995).[8] The *Travelers* Court discussed whether ERISA's preemption provision altered the starting presumption that Congress does not intend to supplant state law. *See id.* at 654-55, 115 S. Ct. at 1676-77, 131 L. Ed. 2d at 704. While observing that this presumption remained unaltered, the Court recognized that its prior attempts to construe "relate to" did not provide much help drawing the line as to what should be preempted. *See id.* at 655, 115 S. Ct. at 1677, 131 L. Ed. 2d at 705. The Court concluded that in order to determine whether the normal presumption against preemption has been overcome in a particular case, it "must go beyond the unhelpful text and the frustrating difficulty of defining [§ 514 (a)'s] key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.* at 656, 115 S. Ct. at 1677, 131 L. Ed. 2d at 705. The Court found that the "basic thrust" of the clause was "to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans," and observed that under its past case law it had found ERISA to preempt state laws that mandated employee benefit structures or their administration. *Id.* at 657-58, 115 S. Ct. at 1677-78, 131 L. Ed. 2d at 706. The use of this approach for "connection with" analysis was subsequently endorsed and used by the Court both in *Dillingham* and *De Buono* and recognized by this circuit in *Davies v. Centennial Life Insurance Co.*, 128 F.3d 934 (6th Cir.

[8] In *De Buono v. NYSA-ILA Medical & Clinical Services Fund*, 520 U.S. 806, 117 S. Ct. 1747, 138 L. Ed. 2d 21(1997), the Court explained its change in focus, stating that its earlier ERISA cases had not required a fine analysis of the scope of ERISA's "relate to" language, because the state laws at issue had a clear "connection with or reference to" ERISA benefit plans. *De Buono*, 520 U.S. at 813, 117 S. Ct. at 1751, 138 L. Ed. 2d at 28-29. The Court explained that in *Travelers*, however, it was forced to confront directly whether ERISA's "relates to" language altered the normal starting presumption that Congress does not intend to supplant state law. *See id.*

1997).[9]

Using the *Travelers* "connection with" analysis, the district court in the case at bar determined that Kentucky's AWP laws had a connection with ERISA plans. The court found that while the law did not operate directly on ERISA plans, it effectively required benefit plans to purchase benefits of a certain structure, thereby bearing indirectly but substantially on all insured plans. As a result, the court concluded that the AWP statutes did more than just indirectly affect the cost of ERISA plans; the AWP statutes mandated benefit structures.

Two other district courts in Kentucky recently drew the same conclusion while addressing the same statute. In *Community Health Partners, Inc. v. Kentucky*, 14 F. Supp. 2d 991, 1000-01 (W.D. Ky. 1998), the court found Kentucky's AWP provision, located then at § 304.17A-110(3), to be similar in effect to the mandated benefit law in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 105 S. Ct. 2380, 85 L. Ed. 2d 728 (1985). In *Metropolitan*, the Supreme Court held that the Massachusetts mandated benefit law "related to" ERISA plans because the statute bore indirectly, but substantially, on all insured employee benefit plans by effectively requiring the plans to purchase mental health benefits when purchasing a certain kind of common insurance policy. *See id.* at 739, 105 S. Ct. at 2388, 85 L. Ed. 2d at 740. Similarly, the *Community Health Partners* court believed that the AWP law effectively mandated the benefit structure of ERISA plans and regulated the relationship between traditional ERISA entities, *i.e.*, the plan, the employer, and the plan fiduciaries and beneficiaries. 14 F. Supp. 2d at 997.

[9] In changing its "relate to" analysis in *Travelers*, the Court appears to have been addressing only the "connection with" prong, as its statements in later cases indicate the "reference to" prong was unaffected. *See De Buono*, 520 U.S. at 815 n.15, 117 S. Ct. at 1752, 138 L. Ed. 2d at 30; *Dillingham*, 519 U.S. at 324, 117 S. Ct. at 837, 136 L. Ed. 2d at 799.

A recent memorandum opinion, *Ward v. Alternative Health Delivery Systems, Inc.*, 55 F. Supp. 2d 694 (W.D. Ky. 1999), held that § 304.17A-171, which contains regulations of a health benefit plan's use of chiropractic services, including an AWP provision, was preempted by ERISA due to its connection with employee benefit plans. *Id.* at 701. The judge found that:

> By specifically prohibiting health organizations from offering networks with limited chiropractic providers, the statute mandates the plan's structure. Moreover, the statute also dictates that all covered participants shall have access to the chiropractor of their choice. This too dictates a certain structure to which an employer's health care plan must succumb. As such this claim also falls within the realm of ERISA preemption.

Id. at 699.

Some academic literature has suggested that the Supreme Court's post-*Travelers* case law may represent a "sea change" in the "relation to" analysis; however, neither the Court's nor the circuits' opinions yet confirm this assertion.[10] The two appellate courts that have addressed the issue since *Travelers* both found that the AWP statutes at issue were "connected with" ERISA covered employee benefit plans. *See CIGNA Healthplan of La., Inc. v. Louisiana,* 82 F.3d 642, 648-49 (5th Cir. 1996); *Texas Pharmacy Ass'n v. Prudential Ins. Co. of Am.* 105 F.3d 1035, 1037 (5th Cir. 1997). In both of these cases, the courts recognized that under the reasoning of *Travelers,* state laws that mandate employee

[10] While Justice Scalia has suggested that the Court should really be applying field preemption, rather than the express preemption test it has created for analyzing ERISA's preemption provisions, *Dillingham*, 519 U.S. at 335-36, 117 S. Ct. at 843, 136 L. Ed. 2d at 806 (1997) (Scalia, J., concurring), absent further direction from the whole Court on this issue we must continue to apply the traditional analysis.

benefit structures are preempted. Finding the AWP statutes at issue did exactly that, both courts concluded that they were trumped by ERISA's preemption provision. *Cf. Stuart Circle Hosp. Corp. v. Aetna Health Management,* 995 F.2d 500, 502 (4th Cir. 1993) (finding, in a case prior to *Travelers,* that Virginia's AWP statute related to ERISA covered employee benefit plans because it eliminated an insurer's ability to choose limited provider networks).

We are convinced that even after the change of emphasis worked by *Travelers* on the "connection with" prong of the Supreme Court's "relation to" preemption analysis, the district court in this case was correct in finding that former § 304.17A-110(3) (now § 304.17A-270) and present § 304.17A-171 were both "connected with" ERISA covered plans. They not only affect the benefits available by increasing the potential providers, they directly affect the administration of the plans.

The Kentucky statutes in question meet both prongs of the "relation to" analysis and thus are preempted, unless found to be statutes that regulate insurance under the savings clause of § 514(b) (2)(A).

III. Insurance Savings Clause

Having concluded that Kentucky's AVWP laws relate to ERISA covered employee benefit plans, and are thus within the scope of ERISA's preemption provision, the Court must then determine whether the laws fall within ERISA's savings clause. The savings clause states that, "[e]xcept as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities." ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). This provision provides a broad and important exception to ERISA's preemption provision, saving state laws that relate to ERISA plans from preemption so long as they "regulate insurance." Much like the preemption provision itself, however, the

scope of the savings clause has proved difficult to determine from its sparse language.[11]

The Supreme Court has endeavored to provide guidance on what it means to "regulate insurance," first addressing the issue in *Metropolitan Life Insurance Co. v. Massachusetts,* 471 U.S. 724, 105 S. Ct. 2380, 85 L. Ed. 2d 728 (1985), and most recently describing the test in *UNUM Life Insurance of America v. Ward,* 526 U.S. 358, 119 S. Ct. 1380, 143 L. Ed. 2d 462 (1999), stating:

> Our precedent provides a framework for resolving whether a state law "regulates insurance" within the meaning of the saving clause. First we ask whether, from a "common sense view of the matter," the contested prescription regulates insurance. Second, we consider three factors employed to determine whether the regulation fits within the "business of insurance" as that phrase is used in the McCarran-Ferguson Act: "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." (internal citations omitted).

Ward, 526 U.S. at 367-68, 119 S. Ct. at 1386, 143 L. Ed. 2d at 472.

The Court noted that the three McCarran-Ferguson factors are "considerations [to be] weighed' in determining whether a state law regulates insurance" and that "[n]one of these criteria is necessarily determinative in itself." *See id.* at 373, 119 S. Ct. at 1389, 143 L. Ed. 2d at 476. Therefore, in determining whether Kentucky's AWP laws are saved from preemption by ERISA § 514(b)(2)(A), one must first ask whether as a matter of common sense they regulate insurance, and then look to the McCarran-Ferguson factors as checking points or guideposts to aid the analysis.

In *Ward,* the Court was faced with the question of whether California's notice-prejudice rule[12] was preempted by ERISA. The parties had agreed that California's notice-prejudice rule "related to" ERISA covered plans under § 514(a), so the Court had only to determine whether the rule was saved by the insurance regulation savings clause of § 514(b)(2)(A). 526 U.S. at 367, 119 S. Ct. at 1386, 143 L. Ed. 2d at 472. The Court began with the common sense prong of its insurance regulation savings clause test, observing that:

> The California notice-prejudice rule controls the terms of the insurance relationship by "requiring the "insurer" to prove prejudice before enforcing proof-of-claim requirements." *Cisneros,* 134 F.3d at 945. As the Ninth Circuit observed, the rule, by its very terms, "is directed specifically at the insurance industry and is applicable only to insurance con-

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[11] *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739-40, 105 S. Ct. 2380, 2389, 85 L. Ed. 2d 728, 740 (1985), in which the Court stated:

> [T]he sphere in which § 514(a) operates was explicitly limited by § 514(b)(2). The insurance savings clause preserves any state law "which regulates insurance, banking, or securities." The two pre-emption sections, while clear enough on their faces, perhaps are not a model of legislative drafting, for while the general pre-emption clause broadly pre-empts state law, the saving clause appears broadly to preserve the States' lawmaking power over much of the same regulation. While Congress occasionally decides to return to the States what it has previously taken away, it does not normally do both at the same time.

[12] The rule states, "a defense based on an insured's failure to give timely notice [of a claim] requires the insurer to prove that it suffered actual prejudice. Prejudice is not presumed from delayed notice alone. The insurer must show actual prejudice, not the mere possibility of prejudice." *Ward*, 526 U.S. at 366-67, 119 S. Ct. at 1386, 143 L. Ed. 2d at 472.

tracts." *Ibid.;* see Brief for United States as Amicus Curiae 12 ("[O]ur survey of California law reveals no cases where the state courts apply the notice-prejudice rule as such outside the insurance area. Nor is this surprising, given that the rule is stated in terms of prejudice to an 'insurer' resulting from untimeliness of notice."). The rule thus appears to satisfy the common-sense view as a regulation that homes in on the insurance industry and does "not just have an impact on [that] industry." *Pilot Life*, 481 U.S. at 50, 107 S. Ct. 1549.

Ward, 526 U.S. at 368, 119 S. Ct. at 1386-87, 143 L. Ed. 2d at 472-73.

Ward makes it clear that the most important aspect of the test is whether from a common sense view of the matter the contested statute regulates insurance. The three McCarran-Ferguson factors are of secondary importance, serving only as "checking points" or "guideposts" and not as essential elements. Indeed, in *Ward,* the Court ignored the first McCarran-Ferguson factor altogether in its analysis of the challenged statute in that case.

The Kentucky Act meets the common sense test in that it clearly does regulate insurance, The fact that it includes within its reach HMOs as well as traditional insurance companies does not take it out of the realm of insurance regulation. We agree with the reasoning of the Ninth Circuit in *Washington Physicians Service Association v. Gregoire,* 147 F.3d 1039 (9th Cir. 1998), in which the Court said:

> The Washington law is "specifically directed" toward the insurance industry, *Pilot Life,* 481 U.S. at 50, 107 S.Ct. 1549, because it operates directly on HMOs and HCSCs, entities that are engaged in the business of health insurance. "The primary elements of an insurance contract are the spreading and underwriting of a policyholder's risk." *Group Life & Health Ins. Co. v. Royal Drug Co.,* 440 U.S. 205, 211, 99 S.Ct. 1067, 59 L. Ed.2d 261 (1979), citing 1 G. Couch, Cyclopedia of Insurance Law § 1:3 (2d ed.1959)("It is characteristic of insurance that a number of risks are accepted, some of which involve losses, and that such losses are spread over all the risks so as to enable the insurer to accept each risk at a slight fraction of the possible liability upon it."). The only distinction between an HMO (or HCSC) and a traditional insurer is that the HMO provides medical services directly, while a traditional insurer does so indirectly by paying for the service, *Anderson v. Humana, Inc.,* 24 F.3d 889, 890 (7th Cir. 1994), but this is a distinction without a difference. *Metropolitan Life,* 471 U.S. at 741,105 S. Ct. 2380 (explaining that nothing in ERISA "purports to distinguish between traditional and innovative insurance laws"); *Klamath-Lake Pharmaceutical Ass'n v. Klamath Med. Serv. Bureau,* 701 F.2d 1276, 1286-87 (9th Cir. 1983). In the end, HMOs function the same way as a traditional health insurer: The policyholder pays a fee for a promise of medical services in the event that he should need them. It follows that HMOs (and HCSCs) are in the business of insurance.

Id. at 1045-46.[13] In *Anderson v. Humana, Inc.,* 24 F.3d 889, 892 (7th Cir. 1994), the court said: "Because HMOs spread risk - both across patients and over time for any given person - they are insurance vehicles under Illinois law." They are likewise "insurance vehicles" under Kentucky law.

It is true that the statutes would reach certain self-insured health care benefit plans that are not under ERISA's protective "deemer" clause, *e.g.,* self-insured government plans and

[13] As noted earlier, the Ninth Circuit in *Gregoire* found that the Washington statute did not come within the scope of ERISA's pre-emption clause. Nevertheless, the Court found that, even if it did, the statute dealt with the regulation of insurance and would therefore be saved from pre-emption.

self-insured church plans, because they are excluded entirely from ERISA's coverage under 29 U.S.C. § 1003(b). We do not see this fact, however, as any barrier to a finding that a common sense view is that the statutes regulate insurance. We know of no reason why it is not within the authority of a state in enacting laws dealing with insurance to include within such laws entities that act as self-insurers as well as entities who purchase insurance. As the author of a well-known treatise has said, "Self-insurance has often led courts and legislatures to struggle with the intriguing question of whether a party who has not purchased insurance, effectively acting as its own insurer, should be the equivalent of an insurer." 1 COUCH ON INSURANCE 3d § 10.2. It is pointed out that this difficulty in modern practice is frequently removed by express statutory provisions specifying that a particular requirement does or does not apply to self-insured entities. *Id.* Kentucky has done this by expressly including self insurers to the extent permitted by ERISA - within the coverage of the statutes in question.

The state's regulation of health benefit plans is set forth in Kentucky's Insurance Code (Chapter 304 of Title XXV dealing with Business and Financial Institutions). Subtitle 17A of the Insurance Code deals with health insurers and health benefit plans. Section 304.17A-005 contains the definition of words used in that subtitle. Paragraph 22 provides:

> "Insurer" means any insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky.

"Health benefit plan" is also defined, the relevant portion of

that definition tracking the above definition of "insurer:"

> "Health benefit plan" means any hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; provider sponsored integrated health delivery network; a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; . . .

Ky. Rev. Stat. Ann. § 304.17A-005(17).

The AWP provision of Kentucky's Insurance Code specifically is directed at "insurers" by providing that:

> A *health insurer* shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer, including the Kentucky State Medicaid program and Medicaid partnerships (emphasis added).

Ky. Rev. Stat. Ann. § 304.17A-270.

The chiropractic AWP provision specifically adopts the definition of a health benefit plan as set forth in Kentucky Revised Statutes Annotated § 304.17A-005 and defines "health care insurer" as any entity "authorized by the state of Kentucky to offer or provide health benefit plans, policies, subscriber contracts, or any other contracts of similar nature which indemnify or compensate health care providers for the provision of health care services." Ky. Rev. Stat. Ann. § 304.17A-170(7).

The Kentucky AWP laws are thus specifically directed toward "insurers" and the insurance industry and are ones that from a "common sense view" regulate insurance.

The fact that the deemer clause prevents ERISA self-

insured plans from being considered as engaging in the business of insurance does not mean that self-insured plans, by their nature, do not involve the business of insurance and are beyond the reach of state regulations dealing with insurance. The distinction between plans funded by the purchase of insurance and plans that are funded by employers as self-insured plans results from "a distinction created by Congress in the 'deemer clause,' a distinction Congress is aware of and one it has chosen not to alter." *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. at 747, 105 S. Ct. at 2393, 85 L. Ed. 2d at 745. It is not a distinction based upon a concept that employers who choose to be self-insurers cannot be considered insurers subject to state regulations dealing with insurance. Therefore, the fact that the Kentucky statute reaches self-insurers who are not protected by ERISA's deemer clause does not detract from its characterization as a statute regulating entities engaged in the business of health insurance.

As noted earlier, the Kentucky statutes exclude from their scope self-insured ERISA plans. If such a plan provides for a limited group of providers, the AWP laws would not compel a change in that plan, regardless of the nature of the entity administering the plan. It could not be enforced, in our opinion, against the employer who has a self-insured ERISA plan nor against the administrator of such a plan, even if the administrator is an entity, such as an HMO, which would be subject to the statute if it were acting not as a mere administrator but as an insurer of its own plan. In *Light v. Blue Cross and Blue Shield*, 790 F.2d 1247 (5th Cir.1986), the court rejected the argument that a state law could be enforced against the administrator of a self-insured ERISA plan because the deemer clause, § 514(b)(2)(B), which protects such plans from state regulation, does not expressly include plan administrators among the exempted entities. The court found the fact that administrators of self-insured plans are not mentioned in the deemer clause to be of no significance, and be-

cause the state law was preempted, the claim against the administrator of the plan based on that law could not be brought, even though the plan itself provided that the contracts between the employer and the plan administrator would "conform to applicable state laws." The court observed that, "If ERISA preempts state law, there is no applicable state law to which the administrator must conform." *Id.* at 1248.

In *Prudential Insurance Company of America v. National Park Medical Center, Inc.,* 154 F.3d 812 (8th Cir. 1998), the court found that an Arkansas statute that contained an AWP provision did not meet the common sense test because, in part, its scope included "employers and administrators of self-insured plans" (although the statute excluded ERISA self-funded plans). As noted above, however, we do not believe that inclusion of self-insurers not protected by the deemer clause, as well as purchasers of insurance, within the statute's reach in itself removes the statute from being viewed a permissible regulation of insurance based upon "a common understanding of insurance regulation." Also, unlike the Arkansas statute, the Kentucky statutes do not include "administrators of self-insured plans." They are di-

rected towards and limited to health care "insurers."[14]

Texas Pharmacy Association v. Prudential Insurance Company ofAmerica,105 F.3d 1035 (5th Cir.1997), contains the statement that if a self-insured employer, not subject to the any willing provider statute, "signed up with an HMO or

[14] The dissent contends that Kentucky's AWP provisions apply to third parties that a self-insured ERISA plan hires to administer its plan benefits. This contention, however, is based upon the dissent's reading of the repealed Kentucky statutes which prohibited "health care benefit plans" from discrimination and defined health benefit plans as including a health service corporation contract and a health maintenance organization contract. The present Kentucky statutes eliminate any ambiguity as to whether administrators under contracts with benefit plans are included within the scope of the statutes. They obviously are not. The current Kentucky statute prohibits *only* "a health *insurer*" from discrimination. Ky. Rev. Stat. Ann. § 304.17A-270. As the defendant correctly notes, "the new statute refers to health insurers which shall not discriminate among providers rather than health care benefit plans which strengthens Appellee's arguments that the AWP law regulates insurance." Brief of Defendant-Appellee, p. 3 n.5. An entity that merely administers a plan for a health insurer and does not participate in the underwriting of the risk is not an "insurer" and is not within the scope of Kentucky's current statutes which are, by their express terms, directed solely at health *insurers*. This is acknowledged by the defendant:

> The statutes establish that health insurers, which assume financial risk, cannot discriminate against qualified providers. Therefore, although the statute tenuously affects the relationship between insurers and providers, its focus is on the contractual relationship between the insurer and the insured.

Brief of Defendant-Appellee, p. 18.

Thus, under the current AWP statute, the insurer of a plan, including a self-insurer of a non-ERISA benefit plan, must not discriminate against qualified providers, and any health benefit plan of such insurer must conform to the statute. While not included as an entity subject to the statute, a plan administrator would necessarily be required to comply with the plan's non-discriminatory requirement. With respect to self-insured ERISA benefit plans, the insurer of such plans is beyond the scope of the statute by its express terms, and the administrators of such plans who act solely as administrators and not as insurers are likewise beyond the scope of the statute because of its application only to health insurers.

PPO, those organizations would be subject to the statute, even if there is no insurance company involved." *Id.* at 1039. The court was presumably referring to the HMO or PPO acting as the administrator of the employer's self-funded plan. We believe, however, that, as the court in *Light* observed, if ERISA preempts the state law with respect to self-funded plans, there is no state law to which the administrator of the self-funded plan must conform. Furthermore, as previously noted, the Kentucky statute is directed toward and applies to only insurers and not to plan administrators. *Supra*, note 14. A plan administrator that does nothing more than administer the plan of a self-insured employer is not engaged in "the underwriting and spreading of risk," *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 221, 99 S. Ct. 1067, 1077, 59 L. Ed. 2d 261, 274 (1979), and in our view, would not be considered an "insurer" of a health benefit plan as that term is used in Kentucky's AWP laws.[15]

[15] The dissent believes that the majority is "apparently saying that the law is clearly preempted and not saved insofar as it applies to plan administrators, and then arguing that due to this preemption, the statute does not apply to entities outside the insurance industry." According to the dissent, this is an "attempt to dissect Kentucky's AWP provisions, dismissing some of the provision's applications as preempted and then applying saving clause analysis only to those applications it wishes to retain." This is a misreading of the majority opinion. The majority does not say that the Kentucky statutes are preempted insofar as plan administrators are concerned. The majority is saying that insofar as self-insured ERISA plans are concerned, the Kentucky AWP laws could not be enforced against a plan administrator, as a matter of law, under the reasoning of *Light*, because if the law is preempted with respect to self-insured plans, "there is no applicable state law to which the administrator must conform." More importantly, however, is the fact that the present Kentucky AWP statute, Ky. Rev. Stat. Ann. § 304.17A-270, prohibits only health *insurers* from discrimination and would have no application to an entity acting merely as an administrator of an insurer's plan. Although the chiropractic statute still refers to a prohibition against "health benefit plans" discrimination, Ky. Rev. Stat. Ann. § 304.17A-171(2), the majority believes that, properly construed, this encompasses insurers of health benefit plans and not mere administrators of such plans.

In *Metropolitan Life*, 471 U.S. at 743-44, 105 S. Ct. at 2391, 85 L. Ed. 2d at 743, the Supreme Court said:

> Congress was concerned [in the McCarran-Ferguson Act] with the type of state regulation that centers around the contract of insurance. . . . The relationship between insurer and insured, the type of policy which could be issued, its reliability, its interpretation, and enforcement - these were the core of the "business of insurance." [T]he focus [of the statutory term] was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the "business of insurance." *SEC v. National Securities, Inc.*, 393 U.S. 453, 460, 89 S. Ct. 564, 568, 21 L. Ed. 2d 668 (1969).

The Kentucky AWP laws deal directly with the relationship between insurers and insureds under health benefit plans. They affect restrictions by the insurers on the number of health care providers available to the insureds under such plans; they increase benefits to the insureds by giving them greater freedom to choose health care providers under the plans; and they are aimed at regulating this insurance relationship. They are part of a comprehensive subtitle of Kentucky's insurance code regulating health benefit plans, and they are, in our view, clearly laws which, in a common sense view of the matter, "regulate insurance" and thus are saved from preemption.

Consideration of the three McCarran-Ferguson factors used in the second step of the analysis as "checking points" or "guideposts" does not require a different result. First, although certainly a debatable issue, we agree with the reasoning of the Fourth Circuit in *Stuart Circle Hospital Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993), that the first factor - "transferring or spreading the policyholder's risk" - is satisfied:

> There are several components to the "policyholder's risk." They include the types of illness and injury that the insurance contract covers, provision for treatment, and the cost of treatment. The Virginia statute affects the type and cost of treatment available to an insured. If a PPO unreasonably restricts the providers of treatment, even though they meet the insurer's standards, it denies an insured the choice of doctor or hospital that may best suit the insured's needs, unless the insured is willing and able to pay all or part of the cost of the doctor or hospital that is not preferred by the insurer. This is a restriction of the insured's benefits. By its prohibition against unreasonable restriction of providers, the Virginia statute spreads the cost component of the policyholder's risk among all the insureds, instead of requiring the policyholder to shoulder all or part of this cost when seeking care or treatment from an excluded doctor or hospital of his or her choice.

Id. at 503.

Plaintiffs point out that the Kentucky statutes in question do not require health benefit plans to contract with any additional provider, but only with providers who are willing to meet the network's terms and conditions. While this is unquestionably true, it does not, in our view, change the fact that the statutes open an otherwise closed door, insofar as the availability of health care providers is concerned. Some may choose to go through that door and join the group of providers while others may not, but this does not mean that removal of a restriction on availability of providers is not a benefit conferred on the insureds. It effectively changes the terms of the policy, admittedly not in terms of covered medical condition but in terms of covered treatment by health

care providers.[16]

While Plaintiffs understandably rely on *Group Life & Health Ins. Co. v. Royal Drug* Co., 440 U.S. 205, 99 S. Ct. 1067, 59 L. Ed. 2d 261 (1979), in support of their position that the first factor is not present in this case, we believe *Royal Drug* does not require that conclusion. Unlike the health plans that are the subject of the Kentucky statutes, the insurer in *Royal Drug* did not restrict the number of providers in question. Blue Cross had offered to enter into a provider agreement with every licensed pharmacy in Texas. The benefit conferred on the insureds by the Kentucky AWP statutes - removal of restrictions on the number of providers - was already present in *Royal Drug*. The Supreme Court expressly noted, with reference to its discussion of contracts between the insurer and providers, "[t]his is not to say that the contracts offered by Blue Shield to its policyholders, as distinguished from its provider agreements with participating pharmacies, may not be the 'business of insurance' within the meaning of the [McCarran-Ferguson] Act." *Id.* at 230 n.37, 99 S. Ct. at 1082, 59 L. Ed. 2d at 279. Unlike Royal *Drug*, policyholders in Kentucky will benefit under their policies by a new change in coverage, insofar as availability

[16] The dissent characterizes this conclusion as "mysterious." There is no mystery, however, in the undeniable fact that there is a difference between a closed network of providers chosen by the insurer and an open network of providers consisting of all providers - including providers preferred by the insured patients - who are willing to agree to the same terms as the other network providers. It is an extremely significant difference and one which not only changes the conditions of the plan but, by opening an otherwise closed door, expands the potential for inclusion of additional equally competent medical providers. It is in this sense that the AWP laws change "the terms of covered treatment by health care providers."

of providers is concerned.[17]

The policyholders in *Royal Drug* were "basically unconcerned with arrangements made between Blue Shield and participating pharmacies." *Id.* at 214, 99 S. Ct. at 1074, 59 L. Ed. 2d at 270. They paid a fixed price ($2.00) to a participating pharmacy for each prescription, and consequently they were not concerned with Blue Shield's cost for those prescriptions. Similarly, the policyholders in Kentucky are basically unconcerned with arrangements made between the insurers and participating providers regarding the insurers' cost for the medical services obtained by the insurers. The Kentucky statutes do not seek to change the terms and conditions of those cost arrangements. They merely require that any provider who is willing to meet the same terms and conditions of those arrangements should be allowed to join the list of participating providers. While Kentucky policyholders may be basically unconcerned with the insurers' compensation arrangements with participating providers, it cannot be said that they are unconcerned with a limitation on the number of such providers and the resulting restriction on their

[17] In *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60 (D. Mass. 1997), the court, in considering a Massachusetts AWP statute, distinguished Royal Drug on the ground that, "[b]y directing insurers to open their networks, the Act should affect the availability of benefits to insureds by increasing their ability to select pharmacies of their choice. This does concern the relationship between insurer and policyholder, and thus may be considered part of the business of insurance." *Id.* at 71-72.

freedom of choice in seeking medical treatment.[18]

The Fifth Circuit has also distinguished *Royal Drug* in its discussion of a prior Texas AWP statute pertaining to pharmacies in *Texas Pharmacy Association v. Prudential Insurance Co. of America,* 105 F.3d 1035 (5th Cir. 1997), agreeing with the reasoning of the Fourth Circuit in *Stuart Circle Hospital Corp.* "Unlike the third-party pharmacy agreements in *Royal Drug,* the prior Texas statute directly regulated the terms of the insurance policy between the insurer and the insured." *Id.* at 1041.

Finally, it should be emphasized, in applying the McCarran-Ferguson factors, that "the focus of McCarran-Ferguson is upon the relationship between the insurance company and its policyholders," and state statutes aimed at regulating that relationship, "directly or indirectly, are laws regulating the 'business of insurance." *United States Dep't of the Treasury v. Fabe,* 508 U.S. 491, 501, 113 S. Ct. 2202, 2208, 124 L. Ed. 2d 449, 459 (1993). In *Fabe,* the Court held that, "[t]here can be no doubt that the actual performance of an insurance contract falls within the 'business of insurance,' as

[18] The dissent states that, "It is true that the AWP laws would likely force insurers to pay higher rates." The economic effect of the AWP laws in question, however, is speculative at best. As one commentator has noted, "While AWP legislation could remove some of the incentive for health care providers to substantially discount their fees, provider reaction will most likely differ according to the number of MCOs (managed care organizations) and providers present in each market." James W. Childs, Jr., *You May Be Willing, But Are You Able?: A Critical Analysis of "Andy Willing Provider" Legislation*, 27 Cumb. L. Rev. 199, 210 (1996-1997). The same author reports that, insofar as any increase in consumer cost is concerned, there is some evidence that health care costs have not risen in those states that have enacted AWP legislation. *Id.* at 212. The possible economic effect on insurers must be weighed against "... the fact that managed care threatens Americans' right to freely choose their provider, and AWP legislation protects that right." *Id.* at 217-218. In any event, the decision of the Kentucky legislature to enact AWP laws is one left to the wisdom of that deliberative body, and the possible economic ramifications of its AWP laws should not concern this court.

we understood that phrase in *Pireno* and *Royal Drug.*" *Id.* at 503, 113 S. Ct. at 2209, 124 L. Ed. 2d at 461. Furthermore, in *Fabe,* the Court distinguished *Royal Drug* on the ground that it was an antitrust law case, and the Court in that case was construing the words, "the business of insurance" contained in the second clause of § 2(b) of the McCarran-Ferguson Act, the antitrust law exemption *(see* 15 U.S.C. § 1012(b)).[19] The first clause, which commits laws "enacted by any State for the purpose of regulating the business of insurance" to the States is, according to the Supreme Court, "not so narrowly circumscribed." *Id.* at 504, 113 S. Ct. at 2209, 124 L. Ed. 2d at 461.

The second McCarran-Ferguson factor is, in our view, unquestionably present in this case. The ability of an insured to select a physician of his or her choice to treat a medical condition covered by the insurance is an integral part of the policy relationship between the insurer and the insured. In *Ward,* the Supreme Court dealt with a state law which required an insurer to show that it was prejudiced by an untimely proof of claim before it could avoid liability. The Court, as noted earlier, did not even pursue the issue of whether the statute satisfied the first factor - the risk alteration factor - because the other two factors verified the common sense view of the statute as one regulating insurance. The Court specifically rejected the argument that the statute was not such a law because it did not change any substantive terms of the insurance coverage.

> We reject UNUM's suggestion that because the notice-prejudice rule regulates only the administration of insurance policies, not their substantive terms, it cannot be an integral part of the policy relationship. *See Metropolitan Life,* 471 U.S. at 728 n.2, 105 S.Ct. 2380

[19] The Court in Royal Drug said, "It is well settled that exemptions from the antitrust laws are to be narrowly construed." 400 U.S. at 231, 99 S. Ct. at 1083, 59 L. Ed. 2d at 280.

> (including laws regulating claims practices and requiring grace periods in catalogue of state laws that regulate insurance).

526 U.S. at 375 n.5, 119 S. Ct. at 1390, 143 L. Ed. 2d at 477.

In Plaintiffs' view, the second factor is not satisfied because the AWP provisions leave the contract terms between the insurer and the insured unaltered, the medical risks remain the same, and even if an insured's provider decides to join the insured's network, the medical coverage remains the same. While it is admittedly true that the AWP laws do not change the substantive terms of the insurance coverage, it is not necessary that the statutes do this before they can be found to be statutes regulating insurance. *Id.* Kentucky's AWP laws do, however, directly impact the insurer-insured relationship because they affect restrictions on the network of providers available for treatment under the plan and they directly affect the administration of the plan. As in *Ward*, the statutes effectively create a mandatory contract term dealing with the manner in which the plan is administered by expanding covered treatment from a closed pool of providers to an open pool of providers. As the Fourth Circuit said in *Stuart Circle Hospital Corp.*, 995 F.2d at 503, "We repeat, treatment and cost are important components of health insurance. Regulations governing these components, such as the Virginia statute, are integral parts of the relationship between insurer and insured." In our view, the second McCarran-Ferguson factor is clearly satisfied.

We also conclude that the third factor - the statute's limitations to entities within the insurance industry - is satisfied. For reasons stated earlier, we believe that entities such as HMOs and self-insurers are engaged in the business of insurance along with the more widely recognized and more traditional commercial insurance companies, and that entities acting solely as plan administrators and not as "health insurers" are not within the scope of the statute. As District Judge

McKinley pointed out in *Community Health Partners:*

> Whatever difference in form or structure that exists as between traditional insurance companies and HMOs, MEWAs, and provider-sponsored integrated health delivery networks is insufficient to establish that Kentucky's AWP law is not limited to entities within the insurance industry. To hold otherwise would require the Court to recognize form over substance and to refuse to recognize the natural evolution of the health insurance industry. *Cf. SEC v. Variable Annuity Life Ins. Co.*, 359 U.S. 65, 71, 79 S. Ct. 618, 3 L. Ed. 2d 640 (1959) (We realize that life insurance is an evolving institution. Common knowledge tells us that the forms have greatly changed even in a generation. And we would not undertake to freeze the concepts of "insurance". . . into the mold they fitted when these Federal Acts were passed.)

14 F. Supp. 2d at 1003-04.[20]

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[20] In *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60 (D. Mass. 1997), a Massachusetts AWP statute, unlike the Kentucky AWP laws, did not exclude ERISA self-insured plans from its coverage. Because such plans are not insurers under the "deemer" clause, the argument was made that the state statute was not directed specifically toward the insurance industry. In rejecting this argument, the court noted that, with reference to ERISA self-insured plans, "any decision holding that the Act is saved from preemption by the insurance saving clause would have to recognize that the Act could not apply to the provision of services to self-insured plans. Because the Act would not apply to these uninsured relationships, it is unnecessary to consider whether the Act would lose its status as an insurance regulation because it purports to cover these relationships." *Id.* at 71 n.9. The court also pointed out that in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 105 S. Ct. 2380, 85 L. Ed. 2d 728 (1985), the fact that the state statute "applied by its terms to self-insured plans did not prevent the Supreme Court from concluding that the statute was limited to the insurance industry. Instead, the deemer clause simply prevented application of the statute to self-insured plans." *Id.* (internal citations omitted).

It must be reiterated and emphasized that the three McCarran-Ferguson factors are not required to be satisfied before a state law can be found to be a law regulating insurance. They are, as the Supreme Court pointed out in *Ward*, nothing more than "checking points" or "guideposts." The basic test is whether, from a common sense view, the Kentucky AWP laws in question regulate insurance. We conclude, as did the two Kentucky District Judges who carefully considered this question, that they do.

IV. Conclusion

With respect to Kentucky's AWP statute, Kentucky Revised Statutes Annotated § 304.17A-270 (Banks-Baldwin 1999), and Kentucky's chiropractic AWP statute, Kentucky Revised Statutes Annotated § 304.17A-171(2) (Banks-Baldwin 1999), the judgment of the district court is affirmed. Because the district court opinion does not discuss the additional requirements imposed by provisions (1) and (3)(8) of § 304.17A-171, dealing with chiropractors and health benefit plans, this case is remanded to the district court for consideration in the first instance of the issue of their preemption by ERISA.[21]

[21] Having concluded that Kentucky's AWP statutes are valid, there is no reason for the majority opinion to discuss any question of severability. The dissent, however, in discussing the question of severability, states that the majority "fails to mention, let alone discuss, how it severs Kentucky's AWP provision in such a manner that it no longer applies to third party plan administrators performing administrative functions for self-insured plans, thereby allowing it to conclude that the provision is saved in all other applications." As noted earlier, *supra*, note 15, this is a misreading of the majority opinion. The majority does not hold that the AWP statutes are preempted as applied to administrators of ERISA self-insured plans. It holds, instead, that because the statutes exclude ERISA self-insured plans, they could not be applied against an administrator of such plans under the reasoning of *Light* and, more importantly, they prohibit only health *insurers* from discrimination and, therefore, exclude entities that act solely as administrators of the insurer's health benefit plan.

DISSENT

KENNEDY, Circuit Judge, dissenting. I write separately with respect to Part III of the majority's opinion to dissent from the majority's conclusion that Ky. Rev. Stat. Ann. §§ 304.17A-270[1] and 304.17A-171(2) (Banks-Baldwin 1995) fall within ERISA's insurance savings clause. I believe that Kentucky's any willing provider laws have little to do with insurance and are not saved from preemption by ERISA's Insurance Savings Clause as they do not regulate insurance as a matter of common sense and fail all three of the McCarran-Ferguson factors.

I. Insurance Savings Clause

A.

The district court in the case at bar devoted only a sentence to the common sense test, merely concluding that, "the common-sense view is that the AWP statutes regulate the business of insurance."[2] Instead the court spent most of its time analyzing the McCarran-Ferguson factors, which significantly overlap the common sense test, being designed

[1] As noted in the majority's opinion, § 304.17A-110(3) was the provision that was actually before the district court. However, both the parties have agreed that this appeal will govern § 304.17A-270 as well, as it is essentially a remodification of § 304.17A-110(3). Accordingly, unless otherwise noted I would apply my analysis of § 304.17A-110(3) to § 304.17A-270 as well.

[2] The district court in the companion case of *Community Health Partners, Inc. v. Commonwealth of Kentucky*, 14 F. Supp. 2d 991 (1998) devoted more room to its discussion of the common sense test. The court concluded that the statute satisfied the common sense test because it affected specific terms of the insurance policy, was located in the insurance code and regulated insurers or insurer related entities. *Id.* at 1001-02. While the district court conducted a careful analysis, I reach a contrary conclusion on all points for the reasons explained below.

largely to guide a court's common sense determination. *See Unum Life Ins. of Am. v. Ward,* 119 S. Ct. 1380, 1389 143 L. Ed. 2d 462 (1999).

As the Supreme Court has generally started its savings clause analysis with the common sense test, I begin there as well. *See id.* at 1386; *See also Davies* 128 F.3d 940-941 (6th Cir. 1997). In doing so, I conclude that the Kentucky AWP laws do not meet the common sense test because they are directed at the contracts between benefit plans and third parties, rather than being specifically directed at the insurance industry. *See Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 50, 107 S. Ct. 1549, 95 L. Ed. 2d 39 (1987) (concluding that to fall within the savings clause a law must be *specifically* directed at the insurance industry, which in part requires that the law define the terms of the relationship between the insurer and the insured, rather than the insurer and a third party). The laws do not change the relationship between the insurer and insureds, as the same medical conditions are covered after the AWP laws as were insured before the passage of these provisions. The underwriting of risk, the traditional earmark of insurance, *see Group Life & Health Ins. Co. v. Royal Drug Co.,* 440 U.S. 205, 211-12, 99 S. Ct. 1067, 1073-74, 59 L. Ed. 2d 261 (1979), is in no way affected. Insureds are not free to attend the provider of their choice, as the AWP laws merely require employee benefit plans to accept previously excluded doctors that are qualified, willing to join the plan, and agree to abide by its terms.

Contrary to the majority's assertions, I believe it is also apparent that Kentucky's AWP laws clearly target more than

just members of the insurance industry.[3] By their terms, Kentucky's AWP laws apply to non-ERISA covered self-insured plans by defining health benefit plans to include "a self-insured plan . . . to the extent permitted by ERISA." §§ 304.17A-100(4)(a) and 304.17A-170(1). This definition includes self-insured plans not regulated by ERISA, such as government plans and church plans, which ERISA excludes from its coverage. *See* 29 U.S.C. § 1003 (b). The result is that these self-insured plans, which, as a matter of common sense ought to be considered as operating outside the insurance industry, are subject to Kentucky's AWP laws. *Cf. Cigna Health Plan of La., Inc. v. Louisiana,* 82 F.3d 642, 649 (5th Cir. 1996) (concluding that the statute was not saved as an insurance regulation because it was not limited to entities in the insurance industry as it applied to entities such as self-funded organizations, Taft-Hartley Trusts, or employers who establish and participate in self-funded trusts or programs as well as various intermediaries); *Blue Cross & Blue Shield of Alabama v. Neilsen,* 917 F. Supp. 1532, 1538-39 (N.D. Ala. 1996) (holding that Alabama's AWP

[3] In addition to traditional insurance companies, Kentucky's AWP laws apply to entities such as HMO's and Health Service Corporations. These entities *might* be argued to fall within the insurance industry *if* they have agreed to accept the risk that the covered individual will need medical services in exchange for a fee. *See Group Life & Health Ins. v. Royal Drug,* 440 U.S. 205, 211, 99 S. Ct. 1067, 1073, 59 L. Ed. 2d 261 (1979) (stating that, "[t]he primary elements of an insurance contract are the spreading and underwriting of policyholder risk"). As such, they may be seen as underwriting policyholder risk and then covering that risk with the provision of medical services, rather than by paying for those services as a traditional insurer would. Given the somewhat subtle distinction in this difference, it could be argued that some HMO's and HSC's are engaged in the business of insurance. *See Washington Physicians Serv. Ass'n v. Gregoire,* 147 F.3d at 1045 (adopting this view); but *see Texas Pharmacy Ass'n,* 105 F.3d at 1038-39 (concluding that the Texas statute was not limited to entities within the insurance industry, as it applied to entities such as HMO's and PPO's). However, as Kentucky's AWP laws also apply to entities that are clearly outside the business of insurance, I believe that it is unnecessary for us to decide this issue.

statutes did not regulate insurance as a matter of common sense because they applied to all employee benefit plans, including self-funded plans, and were thus not specifically directed toward the insurance industry) (vacated in part on appeal by *Blue Cross & Blue Shield of Alabama v. Neilsen*, 142 F.3d 1375 (11th Cir. 1998) due to mootness after the Alabama Supreme Court determined in a certified question that the law at issue did not apply to plaintiff); *Stuart Circle*, 995 F.2d at 503-04 (concluding that the AWP statute at issue, which *only* applied to insurance companies actively issuing insurance policies, met the common sense test as a law regulating insurance).

Significantly, the AWP provisions also apply to third parties that a self-insured ERISA plan hires to administer its plan benefits. As used in §§ 304.17A-110(3) and 304.17A-171, "health benefit plan" also included Hospital, Health Service Corporation, and HMO contracts.[4] Section 304.17A-270 uses the term "Health Insurer" instead of "Health Benefit Plan," but similarly defines it to include any Insurance

[4] Section 304.17A-100(4)(a) defined "Health Benefit Plan" as including:

> Any hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; a health benefit plan offered by a provider-sponsored integrated health delivery network; a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; and standard and supplemental health benefit plan as established by KRS 304.17A-160.

Ky. Rev. Stat. Ann. § 304.17A-100(4)(a). Section 304.17A-170 supplies a nearly identical definition of "Health Benefit Plan" (by reference to § 304.17A-005) for § 304.17A-171.

Company, HMO, or HSC.[5] Thus, Kentucky's AWP laws, by there very terms, prohibit *all* HMO's, HSC's and Insurance Companies from "discriminat[ing] against any provider who is located within the geographic coverage area of the health benefit plan . . . ." *See* §§ 304.17A-110(3) and 304.17A-171. The AWP laws would clearly apply to HMOs, HSCs, or Insurance Companies providing plan administration services, as there is nothing in the statute that would exclude them in such a scenario.

Although HMOs, HSCs, and Insurance Companies may accept risk in some situations, as third party administrators they would merely be contracting to handle paperwork and plan administration for a self-insured ERISA plan. While handling such administrative duties, however, these entities would be forced by Kentucky's AWP laws to accept any willing provider into the plan, even though they were not underwriting any risk. The law in this instance is not directed at the business of insurance, as no insurance is involved. *See*

[5] As observed in part I of the majority opinion, § 304.17A-270 recodified § 304.17A-110(3), merely substituting "Health Insurer" for "Health Benefit Plan," and leaving the AWP provision otherwise unchanged. Section 304.17A-005 defines "Insurer," as used in § 304.17A-270, as:

> [A]ny insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider sponsored integrated health delivery network; self-insured employer organized association, or nonprofit hospital medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky.

Ky. Rev. Stat. Ann. § 304.17A-005 (Banks-Baldwin 1999). This definition largely tracks repealed § 304.17A-100(4)(a)'s definition of "Health Benefit Plan." Despite the majority's claim that the substitution of the term "Health Insurer" for "Health Benefit Plan" in the current statute excludes administrators under contract with benefits plans from the scope of the statutes, the definition of "insurer" continues to include plan administrators.

Prudential Ins. Co., 154 F.3d at 829 (observing that the Arkansas AWP statute at issue defined health benefit plans so broadly as to include plan administrators and thus did not fit within a common sense view of a law directed specifically toward the insurance industry); *Texas Pharmacy Ass'n v. Prudential Ins. Co. of America*, 105 F.3d 1035, 1039 (5th Cir. 1997) (noting that a self-insured employer would not be subject to Texas' AWP statute, "but if the employer signed up with an HMO or PPO, those organizations would be subject to the statute, even if there is no insurance involved"); *Cigna Health Plan of La., Inc.* 82 F.3d at 649 (concluding that Louisiana's AWP law was obviously not limited to entities within the insurance industry, in part because it applied to "health care financiers, third party administrators, providers, or other intermediaries"). The only risk underwritten is that accepted by the ERISA self-insured plan, which under the "deemer clause" of ERISA § 514 (b)(2)(B), 29 U.S.C. § 1144(b)(2)(B), cannot be treated as an insurance company for the purposes of state regulation. *See FMC Corp. v. Holliday*, 498 U.S. 52, 61, 111 S. Ct. 403, 409, 112 L. Ed. 2d 356 (1990); *Texas Pharmacy Ass'n*, 105 F.3d at 1039. The common sense conclusion that can be drawn from the AWP statute's coverage of entities clearly operating outside of the business of insurance is that the statute is concerned generally with regulating provider access to networks rather than specifically regulating the business of insurance.[6] *See Prudential Ins. Co.*, 154 F.3d at 829 (concluding that the AWP law at issue was "not a law directed at the insurance industry at all, but a law directed at regulation of broadly defined health benefit plans, only some of which fall within the insurance industry").

The majority seeks to refute this conclusion by arguing

[6] The fact that §§ 304.17A-110(3) and 304.17A-171(2) happen to be codified amongst Kentucky's insurance provisions does not alter this conclusion, as it in no way assures that the law is specifically directed toward the insurance industry.

that Kentucky's AWP law would not apply to entities performing only plan administration for self insurers, apparently on the grounds that to the extent that Kentucky's AWP law seeks to do so, they would be preempted by ERISA. In support the majority cites *Light v. Blue Cross and Blue Shield of Alabama, Inc.*, 790 F.2d 1247, 1248 (5th Cir.1986), which holds that state laws which apply to administrators of self insured plans may be preempted by ERISA and "if ERISA preempts state law, there is no applicable state law to which the administrator must conform." Other courts have drawn a similarly unremarkable conclusion. *See Insurance Bd. Under Social Ins. Plan of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408, 410-13 (3d Cir. 1987) (concluding that Blue Cross and Blue Shield, which provided plan administration services for a self-insured employee benefit plan, were not engaged in the business of insurance and therefore that the state mandated benefit laws were preempted with respect to not only the underlying self-insured plan, but also the plan administrators).

Light, however, is inapposite to the proposition the majority ultimately seeks to advance, that is, if Kentucky's AWP law does not apply to self-insurers, *a fortiori*, it also does not apply to entities administering the self-insured plan. The employee benefit plan at issue in *Light* contained a provision stating that "the contracts between South Central Bell and the plan administrator necessarily will conform to applicable state laws." *Id.* at 465. Plaintiffs argued that since the plan adopted state law, the plan administrator was required to comply with that law. The Fifth Circuit began by noting that if ERISA preempted state law, there would be no state law for the administrator to conform to. The court then turned to Plaintiffs' argument that the preemption provision of 29 U.S.C. § 1144(a) should not be read to apply to plan administrators. Plaintiffs asserted that because their action was against a plan administrator, it did not relate to an employee benefit plan, and therefore was not preempted. The

court found no merit in plaintiffs' argument because, "[a]bsent ERISA the state common law on which [plaintiffs] rely would provide causes of action for the improper handling of claims under benefit plans," giving the law a "direct connection" with employee benefit plans. *Id.* at 1249. As a consequence, the court found § 1144 preempted plaintiffs' state causes of action with respect to the administrator of their self-insured plan as well. *Id.*

In the case at bar, the majority states that based in part on reliance on *Light,* it does not believe that Kentucky's AWP law could be enforced against plan administrators of self-insured plans. The majority appears to arrive at this conclusion due to its belief that, as in *Light,* Kentucky's AWP statute would be preempted insofar as it applies to plan administrators, given that Kentucky's AWP statute "relates to" employee benefit plans. However, having concluded that the *entire* AWP provision is preempted, the majority fails to apply savings clause analysis to the *entire* AWP provision. As I have discussed, Kentucky's law, by its very terms, does attempt to regulate entities outside the insurance industry, through its regulation of HMO and HSC and Insurance Company contracts, which would include contracts purely for plan administration. The majority attempts to ignore this fact by summarily concluding that the law would not apply to plan administrators. However, in doing so the majority is apparently saying that the law is clearly preempted and not saved insofar as it applies to plan administrators, and then arguing that due to this preemption, the statute does not apply to entities outside the insurance industry. The majority cites no authority for its attempt to dissect Kentucky's AWP provisions, dismissing some of the provision's applications as preempted and then applying saving clause analysis only to those applications it wishes to retain. In applying the common sense test we should be looking at the whole provision, not determining whether portions of a provision are saved in some, but not all scenarios.

In sum, unlike *Ward*, where the notice-prejudice rule was by its very terms "directed specifically at the insurance industry and [was] applicable only to insurance contracts," 119 S. Ct. at 1386, Kentucky's AWP laws clearly apply to entities and contracts outside the insurance industry.[7] As a result, I must conclude that §§ 304.17A-110(3) and 304.17A-171(2) do *not* "satisfy the commonsense view as . . . regulation[s] that hone in on the insurance industry" but rather the provisions "just have an impact on [that] industry." *See Ward*, 119 S. Ct. at 1387 (quoting *Pilot Life,* 481 U.S., at 50, 107 S.Ct. at 1554).

B.

Next I "consider [the] three factors employed to determine whether the regulation fits within the 'business of insurance' as that phrase is used in the McCarran-Ferguson Act: first whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is lim-

[7] In an attempt to dismiss the problem of partial preemption (insofar as applied only to plan administrators), the majority appears to draw a distinction between Kentucky's AWP statute and the AWP statute at issue in *Prudential Ins. Co.*, on the grounds that Kentucky's statute does not specifically state that it applies to "plan administrators." However, §§ 304.17A-110(3) and 304.17A-171(2) apply to "Health Benefit Plans," defined to include HMO and HSC contracts. Similarly, § 304.17A-270 applies to "Health Insurers," defined to include all Insurance Companies, HMOs and HSCs. These definitions in no way limit the applicability of Kentucky's AWP provisions to entities underwriting risk. Consequently, if a self-insurer entered into a contract with an HMO, HSC, or Insurance Company solely for the provision of plan administration, there is no reason that the AWP laws would not apply. A plain reading of the AWP provision compels this conclusion regardless of the law's applicability to the self-insured entity the HMO or HSC contracted with. Consequently, one can only conclude that the AWP provisions are preempted, as by their terms they apply directly to HMO's and HSC's that have merely agreed to operate as administrators of self-insured employee benefit plans.

ited to entities within the insurance industry." *Ward*, 119 S.Ct. at 1386 (internal citations and quotations omitted). The McCarran-Ferguson factors only serve to reinforce my conclusion that Kentucky's AWP laws are not saved from preemption by ERISA § 514(b). While none of the McCarran-Ferguson factors should be seen as dispositive, they provide helpful guideposts for savings clause analysis, lending depth and guidance to the common sense test, particularly in difficult cases such as the one we are presented with. *See Ward* 119 S. Ct. at 1389. With this understanding I begin by considering whether Kentucky's AWP laws have the effect of transferring or spreading policyholder risk.

Appellees argue, and the majority agrees, that the district court was correct in finding that Kentucky's AWP laws spread policyholder risk. The district court reached this conclusion because it believed the laws were similar to the mandated benefit laws that the Supreme Court found to spread risk in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). According to the district court, risk was spread because Kentucky's AWP laws made it more likely that an insurer would cover a visit to a provider that the policyholder may have paid to visit on his or her own, due to the policyholder's preference for that particular provider.

I disagree with the district court's attenuated risk spreading analysis and find its analogy to *Metropolitan Life* to be misplaced. *Metropolitan Life* involved a Massachusetts law which required insurers to provide certain minimum mental health benefits to Massachusetts residents. *Id.* at 724, 105 S. Ct. 2380. While applying the McCarran-Ferguson factors to the Massachusetts law, the Supreme Court concluded that risk was being spread because the statute was intended "to effectuate the legislative judgment that the risk of mental-health care should be shared." *Id.* at 743, 105 S. Ct. 2391.

Mandated benefit laws like the one at issue in *Metropolitan Life* require an insurer to treat individuals with health

care conditions that may not have been covered before the law. The effect of such laws is to shift a significant degree of risk from individuals who originally had no such coverage under the insurance policy, to the insurer. Although a closer question, the same can likely be said for mandated provider laws. Under such laws, an insurance company must provide coverage for treatment from any category of provider,[8] which typically broadens insurance coverage to include forms of alternative medicine (e.g., chiropractic, massage therapy, acupuncture) not previously covered under the policy. The Ninth Circuit confronted such a law in *Washington Physicians Serv. Ass'n v. Gregoire*, 147 F.3d 1039 (1998). In analyzing whether the law fell under the savings clause as a law regulating insurance, the court began by recognizing that:

> Because insurance is the business of spreading risk, Royal Drug, 440 U.S. at 205, 99 S. Ct. 1067, a state law that regulates the relationship between a carrier and a provider without affecting the risk borne by the insured is outside the definition of insurance regulation. Id. at 213-214, 99 S. Ct. 1067; Hahn v. Oregon Physicians Serv., 689 F.2d 840, 843-844 (9th Cir. 1982).

Id. at 1045. The court concluded, however, that by expanding the kinds of treatment that an insurer must cover to include various types of alternative medicine, the risk that the insured might need alternative medical treatment was shifted to the insurance company. *See Gregoire*, 147 F.3d at 1046. In reaching this conclusion, the court distinguished Washington's mandatory provider law from AWP laws, noting that the mandatory provider statute did not require any carrier to contract or deal with any particular provider; instead it merely forbade a carrier from excluding a particular

[8] The insurance company's ability to use limited provided networks remains unaffected by such a law.

class of provider. *See Gregoire* 147 F.3d at 1046.[9]

AWP statutes such as Kentucky's are different in purpose and effect than either the mandatory benefit or mandatory provider statutes respectively at issue in *Metropolitan Life* and *Gregoire*. Rather than shifting risk from policyholders to insurers, Kentucky's AWP statutes merely prohibit benefit plans from excluding qualified providers who want to join the plan's provider network and are able to meet the plan's requirements. The risk assumed by the benefit plan under its policy, that the policyholder will require medical treatment, remains unaltered. The statute's passage in no way alters the terms of the policyholder's policies.[10] The only contracts affected are those between the benefit plan and the providers already in the plan network. Kentucky's AWP laws do not *require* that a single doctor be added to any benefit plan network; benefit plans may still maintain provider networks which require doctors to meet certain terms before joining and the plans may still require that policyholders see plan doctors for their medical costs to be covered. *See* Gary A. Francesconi, Erisa *Preemption of "Any Willing Provider" Laws-An Essential Step Toward National Health Care Reform*, 73 Wash. U. L.Q. 227, 248-49 (1995) (observing that with or without the any willing provider law, the insured's access to certain providers is limited by the policy).

[9] As to the issue of whether AWP laws spread risk, the *Gregoire* court stated that it expressed no opinion. *Gregoire*, 147 F.3d at 1047.

[10] The majority mysteriously concludes that the provision changes the policy between the insured and insurer, "not in terms of covered medical conditions, but in terms of covered treatment by health care providers." However, both the medical risks and corresponding treatment covered by the insurer remain unaltered by Kentucky's AWP law. Consequently, I assume that by this statement the majority really means that by *potentially* expanding the number of plan doctors that one could go to receive treatment for a covered condition, the AWP law somehow changes the contract between the insurer and insured.

While doctors who meet the plans qualifications may independently decide to join the plan and the plan must accept them, many doctors may not meet the plan's qualifications or may have no desire to join that particular plan. For example, in an area with multiple benefit plans, a relatively small percentage of additional qualified doctors may decide to join any particular plan network. In such a scenario, many doctors may already be members of several plan networks and may have no desire to enroll in additional networks. Even those qualified doctors who were previously excluded from all the plans in such an area would be unlikely to join every plan after the AWP law. The result is that although Kentucky's AWP laws make it marginally more likely that a policyholder's benefit plan network will contain their preferred doctor,[11] they will still be restricted to the doctors in their benefit plan network regardless of the membership or non-membership of their preferred doctor.

The Supreme Court discussed the transfer of policyholder risk in detail in *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 99 S. Ct. 1067, 59 L. Ed. 2d 261 (1979). The Court was considering whether agreements between Blue Shield and participating pharmacies concerning the price that policyholders would pay for prescriptions, constituted the business of insurance. Under the agreements, the participating pharmacies would fill any Blue Shield policyholder's prescription for a two-dollar charge. *See id.* at 209, 99 S. Ct. at 1072. The pharmacy was then entitled to reimbursement from Blue Shield for the cost of acquiring the drugs prescribed. *See id.* The Court found that, under the antitrust exemption provision of the McCarran-Ferguson Act, 15 U.S.C. § 1012(b), the arrangement did not constitute the "business of insurance" because Blue Shield's agreement with the pharmacies merely limited the *amount* that it would

[11] If their doctor met the plans qualifications, had wanted to join the plan, but was denied membership, that doctor could no longer be kept out of the network if he or she still wished to join.

have to pay to cover its policyholder risks. *See id.* at 214-15, 99 S. Ct. at 1075. While realizing that the policyholders might ultimately benefit in the form of lower rates charged by Blue Shield, the Court concluded that no additional policyholder risks were being underwritten. Instead, the Court saw the agreements as merely arrangements for the purchase of goods and services by Blue Shield and thus not the "business of insurance." *See id.* at 214, 99 S. Ct. at 1075.

The majority attempts to distinguish *Royal Drug* on the grounds that "[u]nlike the health plans that are the subject of the Kentucky statute, the insurer in *Royal Drug* did not restrict the number of providers in question." However, the insurer in *Royal Drug* merely *offered* to enter into agreements with each licensed pharmacy in Texas. This is significantly different from actually entering into such agreements, because, as the Supreme Court observed, "only pharmacies that can afford to distribute prescription drugs for less than this $2 markup can profitably participate in the plan." *Id.* at 209, 99 S. Ct. at 1072. As a result, the insurer's promise to enter into agreements with all pharmacies was essentially an empty one, as only larger, high volume pharmacies could afford to enter into such an agreement. Such a hollow offer provides no real basis to distinguish the case from the limited provider networks at issue in the case at bar.

Similarly, Kentucky's AWP laws have almost no effect on the policyholder risk that insurers must underwrite. Like Blue Shield's unchanged obligation to cover a policyholder's prescriptions after entering into the pharmacy agreements, Kentucky insurers must cover the same medical procedures after the AWP law as they would have to if the AWP provision had not been enacted. It is true that the AWP laws would likely force insurers to pay higher rates, however, as in *Royal Drug*, this would only affect the price that insurers must pay for procedures covered in the policies they have issued, not the type of policyholder risks that they con-

tractually must cover.[12] *Accord*, *Prudential Ins. Co.*, 154 F.3d at 828 (finding that the Arkansas AWP statute plainly did not spread risk, and noting that appellants did not even attempt to argue to the contrary).

In discussing the nature of insurance, the *Royal Drug* Court referred to *SEC v. Variable Annuity Life Ins. Co.*, 359 U.S. 65, 79 S. Ct. 618, 3 L. Ed. 2d 640 (1959), quoting it for the proposition that "the concept of insurance involves some investment risk-taking on the part of the company." The Court noted that while petitioners didn't dispute this fact, they maintained that the pharmacy agreements did involve the underwriting of risk. To this end, they argued that Blue Shield accepted a premium and assumed the risk that policyholders would need prescription drugs by agreeing to enter into contracts with existing pharmacies to provide such drugs for promised reimbursement from Blue Shield. The Court observed that "the fallacy of petitioner's position is that they confuse the obligations of Blue Shield under its insurance policies, which insure against the risk that the policyholders will be unable to pay for prescription drugs during the period of coverage, and the agreements between Blue Shield and the participating pharmacies, which serve only to minimize the costs Blue Shield incurs in fulfilling its underwriting obligations." The court then noted that the benefit promised to the policyholders, that they would only have a two-dollar co-payment for any prescriptions, remained unchanged by

[12] Under Kentucky's AWP law, benefit plans can no longer guarantee a limited panel of providers to which other doctors will not be added to handle the plan's patients. To the extent that contracts between benefit plans and providers contained such exclusivity provisions, under the majority's holding they will no longer be enforceable. While the likely result is an increase in the price that insurers must pay, this is not because of an increase in risk, but rather it is due to a decrease in the volume discount an insurer can command if policyholders are spread across a potentially larger network of plan doctors. *See Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 213-15, 99 S. Ct. 1067, 1074-76, 59 L. Ed. 2d 261 (1979).

the arrangement.

As a result the court concluded that Blue Shield's arrangements left policyholders basically unconcerned (from a financial perspective) about the arrangements Blue Shield entered into with participating pharmacies. This is not to say that at least some participants would not be disappointed by the fact that their pharmacy of choice might not have been included, if for example it was not large enough to provide prescriptions for only a two-dollar markup. However, the *financial risks* that Blue Shield agreed to cover remained unchanged, leaving the policyholders without concern for Blue Shield's cost savings agreements with the larger pharmacies.

As the majority notes, in the case at bar the policyholders were also unconcerned with the insurer's compensation arrangements. However, the majority concludes that the policyholders *were* concerned with restrictions on their freedom of choice in seeking medical treatment. Ignoring for a moment the fact that Kentucky's AWP laws do not allow policyholders the freedom to choose their own doctor, and thus only addresses this concern in at best a very tangential way, any concerns over freedom of choice are beside the point. The critical issue with respect to the risk spreading prong, as well as whether the law regulates insurance as a matter of common sense, is whether or not the law is related to the risks underwritten by the insurer. As the Court noted in *Royal Drug*, while discussing the meaning of "business of insurance" under the McCarran-Ferguson Act: "It is important, therefore, to observe at the outset that the statutory language in question here does not except the business of insurance companies from the scope of the antitrust laws. The exemption is for the 'business of insurance,' not the 'business of insurers.'" *Id.* at 210-11, 99 S. Ct. at 1073. Because Kentucky's AWP laws seek to merely regulate the "business of insurers" by dictating how they structure their provider networks, irrespective of the risks they underwrite, they should

not qualify for savings clause protection.

The majority points to *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993), as support for its contention that Kentucky's AWP laws do transfer risk. *Stuart Circle* involved a Virginia statute which required insurers to accept any willing provider if they established preferred provider networks. The court concluded that while the statute "related to" ERISA plans, it was not preempted, because it fell within ERISA's savings clause as a law regulating insurance. *Id.* at 504. After finding the common sense test satisfied, in part because the law was located within Virginia's insurance code,[13] the court moved on to the McCarran-Ferguson factors. Discussing whether the law transferred or spread policyholder risk, the court concluded that the Virginia statute "affects the type and cost of treatment available to an insured." *Id.* The court reached this conclusion because it believed that without the AWP law, policyholders might on occasion attend a doctor outside of their plan network, due to a personal preference for that doctor, and in doing so, would be forced to shoulder all or part of the cost. *See id.*

I am underpersuaded by the majority's argument that *Stuart Circle's* attenuated risk spreading rationale should be applied to Kentucky's AWP laws. As I have discussed, Kentucky's AWP laws do not require health benefit plans to in-

[13] As indicated above, this fact should have little to do with determining whether a law is specifically directed at the insurance industry, as any law may be inserted within the insurance provisions of a state code. Further, the Virginia statute at issue, § 38.2-3407, only applied to "insurers," defined within the Chapter to mean "an insurance company" which is itself defined as "any company engaged in the business of making contracts of insurance." Va. Code Ann. § 38.2-100. Thus, Virginia's AWP statute was more narrow in scope than Kentucky's, quite specifically limiting its application to the term "insurance companies," defined by the statute to include only companies actively issuing insurance contracts. Consequently, Virginia's statute would clearly not apply to entities engaged in only administrative functions for an employee benefit plan.

clude a single additional provider unless the qualified provider, not the policyholder, decides to join the plan. Policyholders are not necessarily any better off than they were before the law was passed, only benefiting from the law if their provider is both willing to join their particular provider network and able to meet its requirements. The insurance policy and the contingencies it underwrites, *i.e.*, the risk that insured will need medical treatment for a condition covered under the policy, remain the same, regardless of Kentucky's AWP law.[14] There is no shifting of the risk between the policyholder and insurer that a specific medical contingency will occur.

The majority attempts to escape from *Royal Drug's* teaching by relying on dicta from *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60 (D. Mass. 1997), in which the court questioned "whether the holding of *Royal Drug* may be translated into the ERISA preemption context at all." *Id.* at 72. The *American Drug*

[14] The conclusion that Kentucky's AWP laws are not the business of insurance is supported by the following rhetorical question which the Supreme Court posed in *Royal Drug*. The court addressed a scenario which essentially involved limited provider networks, stating:

> Suppose, for example, that an insurance company entered into a contract with a large retail drug chain whereby its policyholders could obtain drugs under their policies only from stores operated by this chain. The justification for such an agreement would be administrative and bulk-purchase savings resulting from obtaining all of the company's drug needs form a single dealer. Even though these cost savings might ultimately be reflected in lower premiums to policyholders, would such a contract be the "business of insurance?" Or suppose that the insurance company should decide to acquire the chain of drug stores in order to lower still further its costs of meeting its obligations to its policyholders. Such an acquisition would surely not be the "business of insurance."

440 U.S. at 215, 99 S. Ct. at 1075. If such agreements are not the "business of insurance," then it follows that a state's attempts to regulate these agreements would not qualify as such either.

Store court was referring to the fact that *Royal Drug* interpreted the scope of the antitrust exemption under § 2*(b)* of the McCarran-Ferguson Act, but did not address §§ 1 and 2(a) of the act, which preserved a State's ability to regulate the "business of insurance" from Commerce Clause attack. *See Royal Drug*, 440 U.S. at 219 n.18, 99 S. Ct. at 1077.[15] However, the Supreme Court has not indicated that it is troubled by this distinction. As recently as last term, the Court employed the McCarran-Ferguson factors it created in *Royal Drug* and imported into ERISA preemption analysis in *Metropolitan Life*, without any indication that its past precedent interpreting whether a law "regulates insurance" under ERISA's savings clause was called into doubt. *See Ward*, 119 S.Ct. 1380, 1388 (1999).[16] Until the Court indicates that its *Royal Drug* business of insurance test is no longer appropriate in the ERISA savings clause context, something that it has yet to do, I believe we must continue to apply the test as dictated by the Court's precedent.

Moving to the second McCarran-Ferguson factor, I consider whether Kentucky's AWP laws affect an integral part of the policy relationship between the insurer and insured. The majority asserts that the district court was correct in

[15] The majority appears to be persuaded by this reasoning. I do not draw the same conclusion. However, even if the meaning of "business of insurance" was broadened beyond the contractual relationship between the policyholder and insurer, I do not believe that Kentucky's AWP law would qualify. As I have explained elsewhere, Kentucky's AWP laws have at most a speculative and tangential effect on this relationship.

[16] The district court in *Community Health Partners v. Commonwealth of Kentucky*, 14 F.Supp.2d 991 (W.D. Ky. 1998) observed that *United States v. Fabe*, *508* U.S. 491, 113 S. Ct. 2202, 124 L. Ed.2d 449 (1993) might be argued to change and broaden savings clause analysis in the ERISA context. However, other federal courts have not reached this conclusion and the Supreme Courts most recent opinion in *Ward* gives no indication that the Court's savings clause analysis has changed. *See also, Prudential Ins. Co.*, 154 F.3d at 827-828 (concluding that *Fabe* had no effect on savings clause analysis).

finding that Kentucky's AWP laws dictate a substantive term of the contract between the insurer and insured and are thus an integral part of this relationship. As support for this proposition, the majority again cites *Stuart Circle*, which concluded that because Virginia's AWP law affected treatment and cost (through the same attenuated manner in which the court concluded risk was spread) it was integral to the insurer-insured relationship. 995 F.2d 500 at 503.

Again I find *Stuart Circle* unconvincing. The effect of Kentucky's AWP laws center on the insurer-provider relationship. The terms of the insurer-insured relationship are only affected in a very indirect manner, making it difficult to see the AWP laws as integral to that relationship. *See Prudential Ins. Co.*, 154 F.3d at 830 (finding the Arkansas AWP law not to be integral to the insurer-insured relationship, as it defined only the terms between the insurer and providers, and distinguishing *Gregoire* because Washington's any category of provider law *did* affect the insurer-insured relationship by expanding the kinds of treatment the policy must cover). *Cf.*, *Pilot Life Co. v. Dedeaux*, 481 U.S. 41, 50-51, 107 S. Ct. 1549, 1554-55 (1987) (noting that Mississippi's law of bad faith, in contrast to the mandated benefits law in Metropolitan Life, did not define the terms between the insurer and insured, and thus only affected the insurer-insured relationship in an attenuated way). The Court's discussion of California's notice-prejudice rule in *Unum Life Ins. Co. of America v. Ward*, 119 S. Ct. at 1389-90 (1999), provides an illuminating example of what qualifies as an integral policy relationship under the McCarran-Ferguson factors. The Supreme Court observed that:

> [California's notice-prejudice rule] serves as an integral part of the policy relationship between the insurer and insured. *Metropolitan Life*, 471 U.S. at 743, 105 S. Ct. 2380. California's rule changes the bargain between insurer and insured; it effectively creates a

> mandatory contract term that requires the insurer to prove prejudice before enforcing a timeliness-of-claim provision.

Id. In sharp contrast, Kentucky's AWP provisions leave the contract terms between the insurer and insured, unaltered. The relationships directly affected by the law are those existing between insurers and third. parties *(i.e.*, medical providers). As discussed above, the medical risks covered by the policy remain the same. Thus, even if an insured's preferred provider decides to join the insured's network, and complies with its terms in doing so, the medical coverage that the insurer has contracted to underwrite remains unchanged. Unlike the mandated benefit laws at issue in *Metropolitan Life*, the mandated provider law in *Gregoire*, or the mandatory notice-prejudice rule in *Ward*, Kentucky's AWP laws do not force the insurer to offer a benefit to insureds tha. was not available before the law. Rather, Kentucky's AWP laws merely force insurers to potentially make additional contractual arrangements with providers they might otherwise exclude. The medical conditions covered remain unaffected and the insureds are still limited to the plan's network of providers. Therefore, I must conclude that Kentucky's AWP law is not integral to the insured-insurer relationship.

Finally, I consider whether the Kentucky AWP laws are limited to entities within the insurance industry. As discussed under the common sense test, I do not believe this to be the case. The law not only regulates entities that fall outside the traditional definition of insurer, it also extends to include entities in no way involved in underwriting risks. In fact, a review of the statute shows that while it may affect the way that some insurance companies run their business, it has nothing to do with the underwriting of risk, the traditional earmark of insurance. *See Royal Drug*, 440 U.S. at 211-12, 99 S. Ct. at 1073-74. Accordingly, I believe that Kentucky's AWP laws fail the third prong of the McCarran-Ferguson

test as well.

In sum, I am forced to conclude that §§ 304.17A-110(3) and 304.17A-171(2), Kentucky's AWP laws, are not saved from preemption as laws that regulate the business of insurance, because under ERISA § 514(b), they fail to meet not only the common sense test, but also all of the McCarran-Ferguson factors.[17] While federalism concerns prohibit federal courts from lightly preempting acts of a state legislature, I agree with the Eighth Circuit's observation in *Prudential Ins. Co.* that, "it is for Congress, not the courts, to reassess ERISA in light of modern insurance practices and the national debate over health care." *Prudential Ins. Co.*, 154 F.3d at 829-30.

II. Severability

Because I believe that Kentucky's AWP provisions, Ky. Rev. Stat. Ann. § 304.17A-110(3) and 304.17A-171 (2) (Banks-Baldwin 1995), are preempted by 29 U.S.C. § 1144(a) and not saved by the savings clause of 29 U.S.C. § 1144(b)(2)(A), I write separately to address whether the laws should be invalidated in their entirety, or whether the offending provisions of the statutes may be severed in whole or part. While never explicitly stating so, as discussed above, the majority appears to agree that Kentucky's AWP laws are preempted at least in their application to HMOs and HSCs who are performing administrative or related duties for self-insured employee benefit plans. However, despite implicitly drawing this conclusion, the majority still concludes that the AWP law is saved by the insurance savings clause. In doing so, the majority fails to mention, let alone discuss, how it severs Kentucky's AWP provision in such a manner that it no longer applies to third party plan administrators performing administrative functions for self-insured plans, thereby

[17] As we indicated above, the parties have agreed that our holding with regard to § 304.17A-110(3) will serve to determine whether § 304.17A-270 is preempted as well.

allowing it to conclude that the provision is saved in all other applications.

The Supreme Court has often stated that the inquiry into whether a statute is severable is essentially an inquiry into legislative intent. *See, e.g., Minnesota v. Mille Lacs Band of Chippewa Indians,* 119 S. Ct. 1187, 143 L. Ed. 2d 270 (1999); *Zobel v. Williams,* 457 U.S. 55, 64, 102 S. Ct. 2309, 2315, 72 L. Ed. 2d 672 (1982); *Regan v. Time, Inc.,* 468 U.S. 641, 653, 104 S. Ct. 3262, 3269, 82 L. Ed. 2d 487 (1984) (plurality opinion). In discerning the legislature's intent, the Court has directed that:

> Unless it is evident that the legislature would not have enacted those provisions which are within its power, independently of that which is not, the invalid part may be dropped if what is left is fully operative as a law. *Champlin Refining Co. v. Corporation Comm'n of Okla.,* 286 U.S. 210, 234, 52 S. Ct. 559, 76 L. Ed. 1062 (1932). See also *Alaska Airlines, Inc. v. Brock,* 480 U.S. 678, 684, 107 S. Ct. 1476, 94 L. Ed. 2d 661 (1987); *Regan v. Time, Inc.,* supra, at 653, 104 S. Ct. 3262.

Mille Lacs Band of Chippewa Indians, 119 S. Ct. at 1198. Therefore, as evidence of the legislature's intent I look to Kentucky's severability statute, which states:

> It shall be considered that it is the intent of the general assembly in enacting any statute, that if any part of the statute be held unconstitutional the remaining parts shall remain in force, unless the statute provides otherwise, or unless the remaining parts are so essentially and inseparably connected with and dependent upon the unconstitutional part that it is apparent that the general assembly would not have enacted the remaining parts without the unconstitutional part, or unless the remaining parts, standing alone, are incomplete and incapable of being executed in accordance with

the intent of the general assembly.

Ky. Rev. Stat. Ann. § 446.090. The statute indicates that if any part of a Kentucky statute is found unconstitutional, it is the legislature's intent that the remaining provisions be saved. However, in drafting the statute the legislature also recognized that situations will exist where severing the offending parts cannot be considered as it would make it impossible to carry out the original legislative intent.

I begin my severability inquiry by addressing whether portions of Ky. Rev. Stat. Ann. §§ 304.17A-110(3) and 304.17A-171(2) may be severed in such a way that the provisions would not be preempted in their entirety. Because I believe that §§ 304.17A-110(3) and 304.17A-171(2) contain an impermissible connection with ERISA covered plans, there is no way to save the provisions themselves from preemption by severing particular parts while leaving the rest intact. Even if it were possible to do so, merely removing any prohibited "references to" ERISA plans would not suffice. The Kentucky provisions impermissible "connection with" ERISA plans would continue, as ERISA plans would still be effectively prohibited from offering limited provider panels, as none would be available to them. The only way that §§ 304.17A-110(3) and 304.17A-171(2) could be saved, would be to add language effectively allowing health care entities to offer limited provider networks to ERISA covered plans. Because both Kentucky and federal case law prohibit us from adding language to a state statute to remove its conflict with federal law, see, e.g., *Musselman v. Commonwealth*, 705 S.W.2d 476, 477 (Ky. 1986), *Eubanks v. Wilkinson*, 937 F.2d 118, 120 (6th Cir. 1991), I conclude that §§ 304.17A-110(3) and 304.17A-171(2) are preempted in their entirety. *See Prudential Ins. Co.*, 154 F.3d at 832 (concluding that the AWP statute at issue was preempted in its entirety); *Texas Pharmacy Ass'n*, 105 F.3d at 1039 (drawing the same conclusion).

Finally, I address whether the preempted provisions, provision (3) of § 304.17A-110 and provision (2) of § 304.17A-171, may be severed from their respective statutory sections or whether the sections must also be preempted. Kentucky's severability statute indicates that unconstitutional provisions may presumptively be severed, unless severing the offending provisions makes it impossible to execute the remaining provisions of a statute in the manner the legislature intended. It is clear that §§ 304.17A-110 and 304.17A-171 can be executed in accordance with the legislature's original intention without provision (3) and (2) respectively. Accordingly, while I conclude that §§ 304.17A-110(3) and 304.17A-171(2) should be preempted in their entirety, the statutory sections they reside in should remain unaffected.

APPENDIX B

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF KENTUCKY
FRANKFORT

CIVIL ACTION NO. 97-24

HEALTH MAINTENANCE ORGANIZATION ASSOCIATION OF KENTUCKY, INC., et al., Plaintiffs,

v.

GEORGE NICHOLS, III, in his Official Capacity as Commissioner of the Kentucky Department of Insurance, Defendant.

MEMORANDUM OPINION AND ORDER

This matter is before the Court on the parties' cross-motion for partial summary judgment. The plaintiffs, Health Maintenance Organization of Kentucky, Inc., Advantage Care, Inc., Aetna Health Plans of Ohio, Inc., ChoiceCare Health Plans, Inc., FHP of Ohio, Inc., HMPK, Inc., and Humana Health Plan, Inc., submit that partial summary judgment for the plaintiffs is appropriate in this matter as the statutes at hand are preempted by ERISA. The defendant, George Nichols, III, in his official capacity as Commissioner of the Kentucky Department of Insurance ("Commissioner Nichols"), argues, however, that summary judgment is appropriate for him as the statutes at hand only indirectly affect ERISA benefit plans, and thus are not preempted.

Being fully briefed, this matter is ripe for decision. Having considered the parties' arguments, the Court finds that summary judgment is warranted for Commissioner Nichols. Having so determined, the Court makes the following findings of facts consistent with such a determination.

FINDINGS OF FACT

The plaintiffs are licensed health maintenance organizations ("HMOs"), which provide health care services to voluntarily enrolled persons. In order to provide these services within a reasonable cost, the plaintiffs have developed "managed care" programs. Many Kentucky employers have utilized this "managed care" system when offering health care to their employees. Such employer-sponsored health care plans are considered "employee benefit plans" under ERISA.

The plaintiffs have filed this declaratory judgment action, arguing that certain provisions within the Kentucky Health Care Reform Act should be enjoined form enforcement as the provisions either violate the United States Constitution or are preempted by federal law. These provisions are known as Kentucky's "Any Willing Provider" ("AWP") statute and Kentucky's Chiropractic statute, KRS 304.17A-110(3) and KRS 304.17A-171, respectively. Specifically, the plaintiffs contend that these statutes (1) violate the plaintiffs' rights to due process and equal protection and (2) are preempted by ERISA, 29 U.S.C. § 1001, et seq., by the Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e, et seq., and by the Federal Health Benefit Improvement Act, 5 U.S.C. § 8901, et seq.

Pursuant to an agreement by the parties, only Count I of the complaint, alleging that the statutes are preempted by ERISA, is presently before the Court. In their joint status report, the parties agreed that discovery would be had and dispositive motions would be filed only as to Count I. When Count I is resolved, the case will then proceed forward on the other five counts, Counts II-VI. Accordingly, the parties have both filed motions for partial summary judgment as to Count I.

The plaintiffs move the Count for a partial summary judgment, arguing that the AWP and Chiropractic statutes

(hereinafter referred to collectively as the "AWP Statutes)[1] are preempted by ERISA. The plaintiffs subnit that the AWP statutes are preempted by ERISA because the statutes "relate to" employee benefit plans. The plaintiffs submit that the AWP statutes refer to employee benefit plans prohibiting such plans form creating limited provider networks. The plaintiffs maintain, inter alia, that the AWP statues (1) interfere with a plans' ability to negotiate with provicers, (2) impose additional administrative costs on the plan, 3) interfere with a plan's discretion as to how health benefits should be delivered and (4) eliminate a method of structurng benefits that is permissible under ERISA. Accordingly, tle plaintiffs contend that the AWP statutes unconstitutionally intrude upon an area preempted by ERISA, and therefore these statutes must be held invalid and unenforceable under the Supremacy Clause of the United States Constitution.

Commissioner Nichols counters that the AVP statutes are not preempted. He argues that the AWP statutes do not "relate to" employee benefit plans, but instead, such statutes merely have an indirect, economic influence which is too tenuous to require preemption. He states, however, that even if the statutes were to be preempted as "relating to" an employee benefit plan, such statues would be "saved' from preemption because these statutes "regulate" the insurance industry, which is an area exempted from ERISA preemption. However, Commissioner Nichols argues that the Court should not even entertain such preemption argument since the plaintiffs do not have "standing" to bring this suit.

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[1] Although the Chiropractic statute imposes additional requirement s on health benefit plans than does the AWP statute, both statues similarly define "health benefit plan," and thus, the Court will refer to these statutes collectively when determining if they are preempted under ERISA.

[2] The plaintiff also argue that the statutes must be stricken in their entirety and cannot be limited to non-ERISA benefit plans. The Court, however, does not address this issue since the Court has ultimately found that the statute need not be stricken as it is "saved" from preemption.

CONCLUSIONS OF LAW

I. The Plaintiffs Have Standing To Bring This Action

As noted above, Commissioner Nichols argues that the plaintiffs do not have standing to bring this action.[3] The Court does not agree.

The plaintiffs bring this action seeking a declaration that the AWP statute is unconstitutional because it is preempted by ERISA. The plaintiffs have standing to bring such action as they are affected by the terms of the statute in their role as administrators of health benefit plans. It is clear that if the statute is enforced the plaintiffs will suffer economic injury and if the Court grants the HMO plaintiffs the remedy they seek, i.e. preemption, their economic injury would be redressed. See CIGNA Healthplan v. Louisiana, 883 F. Supp. 94, 101 (M.D. La. 1995), aff'd, 82 F. 3d 642 (5th Cir.), cert. denied, 117 S. Ct. 387 (1996). Accordingly, the Court finds the standing argument merit less, and will proceed forward on the issue of whether the AWP statutes are preempted by ERISA.

II. ERISA Preemption

Whether ERISA preempts mandated-benefit or man-

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[3] Commissioner Nichols also argues that the plaintiffs have failed to show that they are in fact administrators of ERISA plans. By the affidavits put forth by the plaintiffs, the Court finds that the plaintiffs have sufficiently shown that they are administrators of employee benefit plans. AS the Sixth Circuit noted, "Employers may establish ERISA plans very easily. As defined under ERISA, employee welfare benefit plans may be created through the mere purchase of a group health insurance policy when the owner does not retain control, administrative power, or responsibility for benefits." Libbey-Owens-Ford v. Blue Cross & Blue Shield Mut., 982 F.2d 1031 (6th Cir.) (internal citations omitted), cert. denied, 510 U.S. 819 (1993; see also Fugarino v. Hartford Life & Accident Ins. Co., 969 F.2d 17, 183 (6th Cir. 1992) ("[I]t is a common practice for employers to provide health care benefits to their employees through the purchase of a group health insurance policy from a commercial insurance company."), cert. denied, 507 U.S. 966 (1993).

dated-provider laws is a subject of great contention. Many courts have addressed this issue, but little agreement has arisen from such decisions.

Some courts have found that the laws doe not even relate to ERISA, and therefore such laws are not preempted. See Washington Physicians Serv. Ass'n v. Gregoire, ___ F.3d ___, 1998 WL 318759 (9th Cir. 1998), rev'g, 967 F. Supp. 424 (W.D. Wash. 1997)); American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc., 973 F. Supp. 60, 69 (D. Mass. 1997); Foster v. Blue Cross Blue Shield, 969 F. Supp. 1020, 1027 (E.D. Mich. 1997). Other courts, including the Federal District Court for the Western District of Kentucky, have determined that the laws do relate to ERISA, but nevertheless are "saved" from preemption because they regulate the business of insurance. See Stuart Circle Hosp. Corp. v. Aetna Health Management, 995 F.2d 500, 501 (4th Cir.), cert. denied, 510 U.S. 1003 (1993); Blue Cross & Blue Shield v. Bell, 798 F.2d 1331, 1336 (10th Cir. 1986); Community Health Partners, Inc. v. Kentucky, ___ F. Supp. 2d ___, 1998 WL 325259 (W.D. Ky. 1998); , ___ F. Supp. 2d ___, 1998 WL 325259 (W.D. Ky. 1998); Texas Pharmacy Ass'n v. Prudential Ins. Co., 907 F. Supp. 1019, 1025-26 (W.D. Tex. 1995), aff'd as modified, 105 F.3d 1035, 1042 (5th Cir.), cert. denied, 118 S. Ct. 75 (1997. Lastly, a few courts have determined that the laws relate to ERISA and are not "saved," since they do not meet the Supreme Court's two-part test for regulating the business of insurance. See Prudential Ins. Co. v. National Park Med. Ctr., Inc., 964 F. Supp. 1285, 1296-99 (E.D. Ark. 1997); CIGNA Healthplan, 883 F. Supp. at 102-104, aff'd, 82 F.3d 642 (5th Cir. 1996); HCA Health Servs. v. Aetna Life Ins. Co., 803 F. Supp. 1132 (E.D. Va. 1992).

Having reviewed the many decisions on this subject, the Court finds that Kentucky's AWP statutes do relate to ERISA plans and are saved from preemption because they regulate the business of insurance.

A. ERISA's Preemptive Structure

ERISA clearly preempts state law which deals with employee benefit plans. 29 U.S.C. 1144(a) (emphasis added) states,

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

Subsection (b), however, goes on to state that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b) (2) (A) (emphasis added). Subsection (b) thus "saves" State law from preemption if the law regulates in three areas set forth.[4]

Yet, within subsection (b), another exception is carved out; this exception is known as the "deemer clause." The "deemer clause" provides that an employee benefit plan

> shall [not] be deemed to be an insurance company or other insurer, bank trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. § 1144(b) (2) (B) (emphasis added). Thus, the "deemer clause" does not allow a state statute to be "saved" when regulating a "self-funded employee benefit plan" under ERISA. See Electro-Mechanical Corp. v. Ogan, 9 F.3d 445,

[4] Thus this subsection is known as the "saving clause."

450-51 (6th Cir. 1993).[5]

In analyzing, then, a State statute such as the one at hand, the first question is whether the state statute "relates to" an employee benefit plan, and therefore is preempted. Looking at the AWP statutes the Court finds the answer to that question to be "yes." The AWP statutes do "relate to" employee benefit plans.

B. AWP Statutes Relate to Employee Benefit Plans Within The Meaning of ERISA

The AWP statutes provide,

> Health care benefit plans shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and is willing to meet the terms and conditions for participation established by the health benefit plan.

KRS 304.17A-110(3); see also KRS 304.17A-171 (stating that a health benefit plan must permit any licensed chiropractor, who is willing to meet the plan's standards, to serve as a provider). Health benefit plan is defined as follows:

> [A]ny hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health

[5] The savings clause limits preemption of state insurance laws to the extent it could be read to "exempt or relieve any person from [state insurance law]." 29 U.S.C. § 1144 (b) (2) (A) (emphasis added). The deemer clause, in turn, qualifies the savings clause and insures that state will not treat ERISA plans as "persons" subject to state laws enumerated in the savings clause. Finally, the MEWA clause is a limited exception to the deemer clause, and allows states to regulate MEWA-sponsored plans as if they were engaged in the business of insurance.

> In this fashion, Congress satisfied its goal of reserving to the states regulation of the business of insurance and protecting ERISA plans themselves from being subjected to state and local regulation.

Fuller v. Norton, 86 F.3d 1016, 1024 (10th Cir. 1996).

> service corporation contract or certificate; a health benefit plan offered by a provider-sponsored integrated health delivery network; a self-insured plan or plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; and standard and supplemental health benefit plan as established in KRS 304.17A-160.

KRS 304.17A-100(4) (a) (emphasis added); see also KRS 304.17A-170(1)(a). Thus, looking at the above provisions it is clear that the AWP statutes "refer to" employee benefit plans. See Mackey v. Lanier Collection Agency & Serv., 486 U.S. 825, 108 S. Ct. 2182, 2186 & n.4 (1988) (statute expressly referred to an employee benefit plan when it singled it out for different treatment); see also De Buono v. NYSA-ILA Med. & Clinical Servs. Fund, 520 U.S. 806, 117 S. Ct. 1747, 1752 & n.15 (1997) (acknowledging that ERISA supersedes laws which contain provisions that expressly refer to ERISA or ERISA plans). But see California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc., 519 U.S. 316, 117 S. Ct. 832, 838 (1998) (noting that "[w]here a State's law acts immediately and exclusively upon ERISA plans" or "where the existence of ERISA plans is essential to the law's operation" the law "refers to" an ERISA plan and is therefore preempted); Community Health Partners, Inc., 1998 WL 325259 at *3 - *4.[6]

[6] The Western District of Kentucky in Community Health Partners, Inc. v. Kentucky, ___ F. Supp. ___, 1998 WL 325259 (W.D. Ky. 1998), determined that Kentucky's AWP statute does not "refer to" an ERISA plan (1) because the law does not act "'immediately and exclusively upon ERISA plans", id. at *3 (quoting Dillingham Constr., N.A., Inc., 117 S. Ct. at 838), and (2) because "the existence of ERISA plans is [not] essential to the law's operation.'" Id. at *4 (quoting Dillingham Constr., N.A., Inc., 117 S. Ct. at 834). The Court, however, does not agree.

Even if the Court were to find that the AWP statutes do not "refer to" ERISA plans, the Court still finds that the AWP statutes are preempted because the statutes have a "connection with" employee benefit plans. The statutes affect how the plans may be administered by requiring such plans to not discriminate as to health care providers, and thus require the plans to contract with "any willing provider." See New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 658 (1995) (looking to prior Supreme Court cases, the Court noted that in those cases "ERISA preempted state laws that mandated employee benefit structures or their administration.")

While such requirements do have an economic impact on the plans, the requirements do more than that; the requirement to contract with "any willing provider" directs the administrator of the plan as to how the plan must be administered, and thus, how the benefit package for the employee must be set up.

Hence, when analyzing the Supreme Court cases dealing with preemption, this case is more closely aligned with Shaw v. Delta Air Lines, Inc. 463 U.S. 85 (1983), than with Dillingham Construction, N.A., Inc., 117 S. Ct. 832 (1997). In Shaw the Court found that New York's Human Rights Law and Disability Benefits Law had a "connection with" employee benefit plans because such laws imposed certain restrictions on the set up of employee benefit plans. The Court

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Both Dillingham Constr., N.A., Inc., 117 S. Ct. at 838, and De Buono, 117 S. Ct. at 1752, cite Mackey for a situation where a statute refers to ERISA or an ERISA plan. Mackey makes it clear that when a statue "singles out ERISA employee welfare benefits plans for different treatment" the statute's "express reference to ERISA plans suffices to bring it within the federal law's pre-emptive reach." Mackey, 108 S. Ct. at 2186. Thus, even though a mere reference to ERISA "alone" may not be sufficient, in this case the AWP statute does not single out and treat ERISA employee welfare benefit plans differently, and thus does "refer to" an ERISA plan so that the statute is preempted.

found,

> We have no difficulty in concluding that the Human Rights Law and Disability Benefits Law "relate to" employee benefit plans. The breadth of § 514(a)'s pre-emptive reach is apparent from that section's language. A law "relates to" an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan. Employing this definition, the Human Rights Law, which prohibits employers from structuring their employee benefit plans in a manner that discriminates on the basis of pregnancy, and the Disability Benefits Law, which requires employers to pay employees specific benefits, clearly "relate to" benefit plans.

Shaw, 463 U.S. at 96-97 (internal footnotes omitted) (emphasis added).

In Dillingham Construction, N.A., Inc., the Supreme Court, however, determined that California's prevailing wage law did not have a "connection with" employee benefit plans because, unlike the statutes in Shaw, the wage law did not mandate any particular structure for benefit plans and only impacted on such plans indirectly. Finding that California's wage law was closely aligned with the law discussed in its most recent decision, Travelers Ins. Co., 115 S. Ct. 1671 (1995), the Court held,

> Like New York's surcharge requirement, the apprenticeship portion of the prevailing wage statute does not bind ERISA plans to anything. NO apprenticeship program is required by California law to meet California's standards ... The effect of § 1777.5 on ERISA apprenticeship programs, therefore, is merely to provide some measure of economic incentive to comport with the State's requirements ...
>
> The effect of the prevailing wage statute on ER-

> ISA-covered apprenticeship programs in California is substantially similar to the effect of New York law on ERISA plans choosing whether to provide health insurance benefits in New York through the Blues, or through a commercial carrier. The prevailing wage statute alters the incentives, but does not dictate the choices, facing ERISA plans. In this regard, it is "no different from myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate." We could not hold pre-empted a state law in an area of traditional state regulation based on so tenuous a relation without doing grave violence to our presumption that Congress intended nothing f that sort. We thus conclude that California's prevailing wage laws and apprenticeship standards do not have a "connection with," and therefore do not relate to," ERISA plans.

Dillingham Construction, N.A., Inc., 117 S. Ct. at 841-42 (internal citations and footnotes omitted) (emphasis added).

Reviewing Shaw and Dillingham Construction, N.A., Inc., then, it is clear that the AWP statutes do more than indirectly affect the costs of ERISA plans; the AWP statutes mandate benefit structures.[7] Thus, the AWP statutes have a "connection with" ERISA plans and are therefore preempted because they "relate to" ERISA plans. As the Fifth Circuit eloquently expressed when looking at Louisiana's "any willing provider statute,"

[7] It is sufficient for preemption purposes that the statute eliminates the choice of one method of structuring benefits. The fact that neither CIGNA nor CGLIC is itself an ERISA plan is likewise inconsequential: By denying insurers, employers, and HMOs the right to structure their benefits in a particular manner, the statute is effectively requiring ERISA plans to purchase benefits of a particular structure when they contract with organizations like CIGNA and CGLIC. In that regard, the statute "bears indirectly but substantially on all insured plans," and is accordingly preempted by ERISA. CIGNA Healthplan, 82 F.3d 642, 648 (5th Cir. 1996) (Internal footnotes omitted).

> Unlike the New York statue at issue in Travelers, Louisiana's Any Willing Provider statute specifically mandate s that certain benefits available to ERISA plans must be constructed in a particular manner. In other words, the Louisiana statute does not merely raise the cost of the implicated benefits; it delineates their very structure. As such, the statute falls outside the purview of the limited Travelers holding: The Court there repeatedly recognized that ERISA preempts "state laws that madate[e] employee benefit structures." Accordingly, we hold that the Travelers decision leaves undisturbed our conclusion that Louisiana's Any Willing Provider statute is preempted by ERISA.

CIGNA Healthplan, 82 F.3d at 649 (internal footnotes omitted).

Having determined that the AWP statutes are more closely aligned with Shaw, and thus "relate to" to employee benefit plans, the AWP statutes will be preempted unless they can be "saved" by ERISA's savings clause. Thus, the question now becomes, do the AWP statutes "regulate the business of insurance?" The Court finds that they do.

C. The AWP Statutes Regulate The Business of Insurance And Therefore Are Saved From Preemption

Whether the AWP statutes are "saved" from preemption by the savings clause is a difficult question and a close call. In determining whether the "savings clause" of ERISA allows Kentucky to enact and enforce the AWP statutes because they regulate insurance, the Court must determine whether the AWP statutes meet the common sense test and

the three factor test under the McCarran-Ferguson Act.[8] Under the three factor test, in order for the statute to be considered as regulating the business of insurance, the statute must

> (1) ha[ve] the effect of transferring or spreading the policyholders' risk
>
> (2) constitute[] an integral part of the policy relationship between the insurer and the insured; and
>
> (3) [be] limited[ed] to entities within the insurance industry.

International Resources, Inc. v. New York Life Insurance. Co., 950 F.2d 294, 299 (6th Cir. 1991) (citing McMahan v. New England Mut. Life Ins. Co., 888 F.2d 426, 429 (6th Cir. 1989)), cert denied, 504 U.S. 973 (1992).

The plaintiffs in their partial motion for summary judgment have made a good argument that the savings clause does not apply in this situation. Nevertheless, the Court finds that the savings clause does apply and that the AWP statutes are laws which "regulate" insurance.[9]

At first blush, it appears that he AWP statutes do not "regulate" insurance (1) because the statutes are directed at not only insurance entities, but also hospitals, HMOs, etc., and (2) because the statutes do not appear to spread the

[8] Unlike some courts, the Sixth Circuit does not require both tests and all factors to be met. The Sixth Circuit instead has stated that "[t]hese criteria must be considered in combination, and, standing alone, no single one is dispositive." Davies v. Centennial Life Ins. Co., 128 F.3d 934, 940 (6th Cir. 1997). Cf. Texas Pharmacy Ass'n v. Prudential Ins. Co., 105 F.3d 1035, 1038 (5th Cir.) (quoting CIGNA Healthplan v. Louisiana, 82 F.3d 642, 650 (5th Cir. 1996)), cert. Denied, 118 S.Ct. 75 (1997).

[9] Although the Court could make an argument that the statute is not "saved," as many courts have done, the Court finds the Supreme Court case of Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 105 S.Ct. 2380, 2390-91 (1985), to be compelling and instrumental in determining that the AWP statute is indeed "saved."

"risk" of insurance since the statutes do not necessarily deal with losses or risk of injury. See Davies v. Centennial Life Ins. Co. v. Massachusetts, 471 U.S. 724, 105 S.Ct. 2380, 2390-91 (1985), the Court cannot help but find that the statute does "regulate" insurance.

In Metropolitan Life Ins. Co., the Supreme court found that a mandated-benefits statute regulated insurance. The Court found that the application of the McCarran-Ferguson Act criteria "suggest[ed] that mandated-benefit laws are state regulation of the 'business of insurance.'" Id. at 2391. In so finding the Court looked at each factor and made the following conclusions:

> Section 47B [mandated-benefit law] obviously regulates the spreading of risk: as we have indicated, it was intended to effectuate the legislative judgment that the risk of mental-health care should be shared. It is also evident that mandated-benefits laws directly regulate an integral part of the relationship between the insurer and the policyholder by limiting the type of insurance that an insurer may sell to the policyholder. Finally, the third criterion is present here, for mandated-benefit statutes impose requirements only on insurers, with the intent of affecting the relationship between the insurer and the policyholder. Section 47B, then, is the very kind of regulation that this Court has identified as a law that relates to the regulation of the business of insurance as defined in the McCarran-Ferguson Act:
>
> > Congress was concerned [in the McCarran-Ferguson Act] with the type of state regulation that centers around the contract of insurance. . . . The relationship between insurer and insured, the *type of policy which could be issued*, its reliability, it interpretation, and enforcement – these were the core of the 'busi-

> ness of insurance.' **[T]he focus [of the statutory term] was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the 'business of insurance.'"** *SEC v. National Securities, Inc.*, 393 U.S. 453, 460, 89 S.Ct. 564, 568, 21 L.Ed.2d 668 (1969) (emphasis added).

Nor is there any contrary case authority suggesting that laws regulating the terms of insurance contracts should not be understood as laws that regulate insurance. **In short, the plain language of the saving clause its relationship to the other ERISA pre-emption provisions, and the traditional understanding of insurance regulation, all lead us to the conclusion that mandated-benefit laws such as § 47B are saved from pre-emption by the operation of the saving clause.**

Id. (emphasis added) (internal footnotes omitted).

Like the mandated-benefits law discussed in Metropolitan Life Ins. Co., the AWP statutes also direct the "type of policy which could be issued," Id. (quoting SEC v. National Securities, Inc., 393 U.S. 453, 460 (1969)), to the employee benefit plans; thus, the statutes regulate an integral part of the relationship between the insurer and policyholder. See Stuart Circle Hosp. Corp., 995 F.2d at 503 (finding that Virginia's "mandated-provider statute is an integral part of the policy relationship because "mandatory-provider regulations are conceptually similar to the mandatory-benefit law that *Metropolitan Life* held was a law regulating insurance"); Bell, 798 F.2d at 1335 (noting that the "freedom to choose a treating physician is inextricable from the nature of the coverage provided" and thus a mandated-provider law is integral to the relationship between insurer and insured).

Likewise, the AWP statutes are similar to the statute in Metropolitan Life Ins. Co. in that the AWP statutes spread the policyholder's risk. Although some courts have determined that mandated-provider laws do not spread the risk because such laws only regulate the carrier-provider relationship and not the insurer-insured relationship, see Gregoire, 967 F. Supp. at 430 ("While there may be an indirect effect, this is insufficient to satisfy this element - it must be integral, and a contract between a carrier and provider is not integral to carrier/subscriber relationship."), rev'd, 1998 WL 318759 (9th Cir. 1998); Prudential Ins. Co., 964 F. Supp. at 1298 ("These contracts and provider networks are related to the insurance contract between insurers and their insureds but are not an integral part of the policy relationship between the insurer and insured."), the Court finds that the mandated-provider laws do regulate more than just the carrier-provider relationship since the laws "effectively transfer some degree of financial risk from the insured to the insurer." Community Health Partners, Inc., 1998 WL 325259 at *12.

> The Virginia [mandated-providers statute satisfies the first criterion, "transferring or spreading the policyholder's risk." **There are several components to the "policyholder's risk."** They include the types of illness and injury that the insurance contract covers, provision for treatment, and the cost of treatment. **The Virginia statute affects the type and cost of treatment available to an insured**. If a PPO unreasonably restricts the providers of treatment, even though they meet the insurer's standards, it denies an insured the choice of doctor or hospital that may best suit the insured's needs, unless the insured is willing and able to pay all or part of the cost of the doctor or hospital that is not preferred by the insurer. This is a restriction of the insured's benefits. **By its prohibition against unreasonable restriction of providers, the Virginia statute spreads the cost component of**

the policyholder's risk among all the insureds, instead of requiring the policyholder to shoulder all or part of this cost when seeking care or treatment from an excluded doctor or hospital of his or her choice.

Stuart Circle Hosp Corp., 995 F.2d at 503 (emphasis added); see also Bell, 798 F.2d at 1335 ("The choice of a provider does not add to the insured's coverage but is of the essence of that coverage bargained for as the transferred risk.").

Lastly, the AWP statutes are "limited to entities 'within the insurance industry, since all carriers are in the business of accepting the risk of providing health care coverage for a fee. The Supreme Court has recognized that a statute which 'impose [s] requirements only on insurers, with the intent of affecting the relationship between the insurer and the Policyholder' satisfies this third prong." American Drug Stores, 973 F. Supp. At 71 (quoting Metropolitan Life Ins. Co., 105 S.Ct. at 2391).

Although the AWP statutes do address entities not deemed traditional "insurers" - entities such as HMOs and provider-sponsored integrated health delivery networks - those entities, within the confines of Kentucky's insurance code, do transact business within the insurance industry and are regulated by the Commissioner of Insurance. As the Ninth Circuit recognized in Gregoire,

> The only distinction between an HMO (or HCSC) and a traditional insurer is that the HMO provides medical services directly, while a traditional insurer does so indirectly by paying for the service, but this is a distinction without a difference. In the end, HMOs function the same way as a traditional health insurer: The Policyholder pays a fee for a promise of medical services in the event that he should need them. It follows that HMOs (and HCSCs) are in the business of insurance."

1998 WL 318759 at *5 (citations omitted), rev'g, Gregoire, 967 F. Supp, at 430 ("While the status of an HMO is a gray area because it possesses certain characteristics of insurance and health care, it appears that its primary mission is health care as opposed to insurance."). Thus, the Court finds that like the mandated-benefit statute in Metropolitan Life Ins. Co., the AWP statutes "impose requirements only on insurers, 105 S.Ct. at 2391. "To hold otherwise would require the Court to recognize form over substance and to refuse to recognize the natural evolution of the health insurance industry," Community Health Partners Inc., 1998 WL 325259 at *13.

Moreover, even if the Court were to agree that the AWP statutes were not directed solely at the insurance industry, see Texas Pharmacy Ass'n, 105 F.3d at 1038-39, CIGNA Healthplan, 82 F.3d at 650, Prudential Ins. Co., 964 F. Supp. at 1298-99; Hayden, 843 F. Supp. at 1436, the Court still holds that the AWP statutes are "saved" since none of the above factors are dispositive and the common-sense view is that the AWP statutes regulate the business of insurance. Again, the Court finds Metropolitan Life Ins. Co. instructive.

In Metropolitan Life Ins. Co., the Supreme Court clearly found unpersuasive the insurers arguments that the mandated-benefit law in question was in reality a health law and not a "traditional" insurance law intended to be saved by, § 514 (b)(2)(A)." 105 S.Ct. 2390. In addressing the insurers argument, the Court emphasized,

> Initially, nothing in § 514(b)(2)(A), or in the "deemer clause" which modifies it; purports to distinguish between traditional and innovative insurance laws. The presumption is against pre-emption, and we are not inclined to read limitations into federal statutes in order to enlarge their pre-emptive scope. Further, there is no indication in the legislative history that Congress had such a distinction in mind.

Appellants assert that state laws that directly regulate the insurer, and laws that regulate such matters as the way in which insurance may be sold, are traditional laws subject to the clause, while laws that regulate the substantive terms of insurance contracts are recent innovations more properly seen as health laws rather than as insurance laws, which § 514(b)(2)(A) does not save. **This distinction reads the savings clause out of ERISA entirely, because laws that regulate only the insurer, or the way in which it may sell insurance, do not "relate to" benefit plans in the first instance. Because they would not be pre-empted by § 514(a), they do not need to be "saved" by § 514(b)(2)(A).** There is no indication that Congress could have intended the saving clause to operate only to guard against too expansive readings of the general preemption clause that might have included laws wholly unrelated to plans. Appellants' construction, in our view, violates the plain meaning of the statutory language and renders redundant both the saving clause it is construing, as well as the deemer clause which it precedes, and accordingly has little to recommend it.

Moreover, it is both historically and conceptually inaccurate to assert that mandated-benefit laws are not traditional insurance laws. As we have indicated, state laws regulating the substantive terms of insurance contracts were commonplace well before the mid-70's, when Congress considered ERISA. The case law concerning the meaning of the phrase "business of insurance" in the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*, also strongly supports the conclusion that regulation regarding the substantive terms of insurance contracts falls squarely within the saving clause as laws "which regulate insurance."

Id. at 2390-91 (emphasis added) (internal footnotes omitted). Thus, having found that the AWP statute "regulates" insurance, the statute is "saved" from preemption."[10]

SUMMATION

The plaintiffs have standing to bring this action. The AWP statutes do "relate to" ERISA plans, and therefore are preempted if they are not "saved" by ERISA's savings clause. Because the statute "regulates" insurance both within

---

[10] Although this issue is not squarely before the Court, the Court notes that the "deemer clause" provides that an employee benefit plan cannot be saved under the "saving" clause as such plan is not considered to be under the "business of insurance." Thus, the Supreme Court has noted that a difference exists between insured and uninsured plans.

> We read the deemer clause to exempt self-funded ERISA plans from state laws that "regulat[e] insurance" within the meaning of the saving clause. By forbidding States to deem employee benefit plans "to be an insurance company or other insurer . . . or to be engaged in the business of insurance," the deemer clause relieves plans from state laws "purporting to regulate insurance." As a result, self-funded ERISA plans are exempt from state regulation insofar as that regulation "relate[s] to" the plans. State laws directed toward the plans are preempted because they relate to an employee benefit plan but are not "saved" because they do not regulate insurance. State laws that directly regulate insurance are "saved" but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws. On the other hand, employee benefit plans that are insured are subject to indirect state insurance regulation. An insurance company that insures a plan remains an insurer for purposes of state laws "purporting to regulate insurance" after application of the deemer clause. The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance, regulations insofar as they apply to the plan's insurer.

FMC Corp. v. Holliday, 498 U.S. 52, 111 S.Ct. 403, 409 (1990). Consequently, insofar as the AWP statutes are "saved" from preemption, the AWP statutes cannot regulate uninsured employee benefit plans and such plans are preempted.

the meaning of the McCarran-Ferguson Act and the common-sense view, the statutes are "saved" from preemption.

Accordingly, with the Court being sufficiently advised,

IT IS ORDERED:

(1) the plaintiffs' motion for partial summary judgment [Record No. 24] be, and the same hereby is, **DENIED.**

(2) the defendant's motion for partial summary judgment [Record No. 36] be, and the same hereby is; **GRANTED.**

This the 6th day of August, 1998.

/s/
JOSEPH M. HOOD, JUDGE

APPENDIX C

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF KENTUCKY
FRANKFORT

CIVIL ACTION NO. 97-24

HEALTH MAINTENANCE ORGANIZATION ASSOCIATION OF KENTUCKY, INC., ET AL., PLAINTIFFS,

v.

GEORGE NICHOLS, III, in his Official Capacity as Commissioner of the Kentucky Department of Insurance, DEFENDANT.

* * * * * * * * *

This matter is before the Court on Plaintiffs' unopposed motion for partial final judgment under Fed. R. Civ. P. 54(b) or alternatively, certification under 28 U.S.C. § 1292(b) [Record 45], and being advised,

IT IS HEREBY ORDERED:

(1) That Plaintiffs' motion for final judgment under Fed. R. Civ. P. 54(b) be, and the same hereby is, **GRANTED;**

(2) that the Court's Order dated August 6, 1988 [Record No. 43] is **FINAL AND APPEALABLE** and **THERE IS NO JUST CAUSE FOR DELAY**.

This is the 17th day of September, 1998. [Filed Sept. 18, 1998.]

/s/
JOSEPH M. HOOD, JUDGE

APPENDIX D

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF KENTUCKY
FRANKFORT DIVISION

CIVIL ACTION NO. 97-24

HEALTH MAINTENANCE ORGANIZATION ASSOCIATION OF KENTUCKY, INC., ADVANTAGE CARE, INC., AETNA HEALTH PLANS OF OHIO, INC., CHOICECARE HEALTH PLANS, INC., FHP OF OHIO, INC., HMPK, INC., PLAN, INC., and HUMANA HEALTH PLAN, INC., PLAINITFFS,

v.

GEORGE NICHOLS III, in his capacity as Commissioner of the Kentucky Department of Insurance, DEFENDANT.

JUDGMENT

Plaintiffs having moved for partial summary judgment pursuant to Fed. R. Civ. P. 56 on Count 1 of their Complaint, and defendant having cross-moved from partial summary judgment pursuant to Fed. R. Civ. P. 56 on Count 1, and the said motions having come before the Honorable Joseph M. Hood, United States District Judge, and the Court thereafter on August 6, 1998 having handed down its opinion granting defendant's motion and denying plaintiffs' motion, it is hereby

ORDERED, ADJUDGED, AND DECREED: That Count I of plaintiff's Complaint is dismissed.

Dated: September 22, 1998

/s/
Hon. Joseph M. Hood

APPENDIX E

98-6308

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., ET AL.,

Plaintiffs-Appellants,

v. ORDER

GEORGE NICHOLS, III, IN HIS OFFICIAL CAPACITY AS COMMISSION OF THE KENTUCKY DEPARTMENT OF INSURANCE,

Defendant-Appellee.

BEFORE: KENNEDY and NORRIS, Circuit Judges; and HOLSCHUH,* District Judge.

The court having received a petition for rehearing en banc, and the petition having been circulated not only to the original panel members but also to all other active judges of this court, and no judge of this court having requested a vote on the suggestion for rehearing en banc, the petition for rehearing has been referred to the original panel.

The panel has further reviewed the petition for rehearing and concludes that the issue raise din the petition were fully considered upon the original submission and decision of the case. Accordingly, the petition is denied.

ENTERED BY ORDER OF THE COURT

[Nov. 20, 2001] /s/
Leonard Green, Clerk

* Hon. John D. Holschuh, Senior District Judge for the Southern District of Ohio, sitting by designation.

APPENDIX F

STATUTORY PROVISIONS INVOLVED

ERISA PREEMPTION PROVISIONS

ERISA's preemption provision, which includes the "savings" clause and the "deemer" clause, is codified at 29 U.S.C. § 1144, and provides in pertinent part:

Section 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

* * *

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

* * *

KENTUCKY GENERAL AWP LAW

Kentucky's general AWP statute provides in pertinent part:

304.17A-005 DEFINITIONS FOR SUBTITLE

As used in this subtitle, unless the context requires otherwise:

* * *

(23) "Insurer" means any insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical- surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky;

* * *

304.17A-270 NONDISCRIMINATION AGAINST PROVIDER IN GEOGRAPHIC COVERAGE AREA

A health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer, including the Kentucky state Medicaid program and Medicaid partnerships.

* * *

KENTUCKY CHIROPRACTIC AWP LAW

Kentucky's chiropractic AWP law provides:

304.17A-171 REQUIREMENTS FOR HEALTH BENEFIT PLANS THAT INCLUDE CHIROPRACTIC BENEFITS

A health benefit plan that includes chiropractic benefits

shall:

(1) Include all primary chiropractic providers who are selected by covered persons of the plan for the provision of all chiropractic benefits provided by the plan which fall within the statutory scope of practice of the respective primary chiropractic provider.

(2) Permit any licensed chiropractor who agrees to abide by the terms, conditions, reimbursement rates, and standards of quality of the health benefit plan to serve as a participating primary chiropractic provider to any person covered by the plan.

(3) Guarantee that all covered persons who are eligible for chiropractic benefits under a health benefit plan shall have direct access to the primary chiropractic provider of their choice independent of, and without referral from, any other provider or entity.

(4) Assure that those plans utilizing a gatekeeper system shall designate the primary chiropractic provider within the scope of practice as the gatekeeper, who shall provide basic patient care and coordinate diagnostic testing, indicated treatment, and specialty referral for those covered persons in the provision of chiropractic benefits. Nothing in KRS 304.17A-170 or this section shall prevent a covered person from having direct access to that person's primary care provider (gatekeeper) for treatment and being reimbursed in accordance with the terms and fee schedule of the health benefit plan.

(5) Not discriminate between individual providers or classes of providers in the amount of reimbursement, copayment, or other financial compensation for the same or essentially similar services provided by the health benefit plan.

(6) Not promote or recommend any individual provider or class of providers to a covered person by any method or means.

(7) Assure that an adequate number of primary chiropractic providers are included as participating chiropractic providers to guarantee reasonable accessibility, timeliness of care, convenience, and continuity of care to covered persons.

(8) Make available to covered persons a listing of all participating primary chiropractic providers, their practice location and telephone number on a regular, timely basis.

Supreme Court, U.S.
FILED
MAY 17 2001
OFFICE OF THE CLERK

(16)

No. 00-1471

In The

Supreme Court of the United States

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., et al.,

Petitioners,

v.

JANIE MILLER, COMMISSIONER OF THE KENTUCKY DEPARTMENT OF INSURANCE,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

BRIEF IN OPPOSITION

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QUESTION PRESENTED

The Sixth Circuit Court of Appeals held that Kentucky's Any Willing Provider ("AWP") statutes, Ky. Rev. Stat. Ann. § 304.17A-270 and Ky. Rev. Stat. Ann § 304.17A-171(2), "regulate insurance" and, therefore, are saved from preemption by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.*

Respondent disagrees with the question presented to this Court by Petitioners. Therefore, Respondent offers the following question for this Court's consideration.

The Question Presented is:

Whether Kentucky's Any Willing Provider statutes, Ky. Rev. Stat. Ann. § 304.17A-270 and Ky. Rev. Stat. Ann. § 304.17A-171(2), are statutes that "regulate insurance" and, therefore, are saved from ERISA preemption?

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STATEMENT OF THE CASE

The Sixth Circuit Court of Appeals, affirming the United States District Court for the Eastern District of Kentucky, ruled that Kentucky's Any Willing Provider ("AWP") statutes, Ky. Rev. Stat. Ann. § 304.17A-270 (formerly § 304.17A-110(3)) and Ky. Rev. Stat. Ann. § 304.17A-171(2), are not preempted by ERISA. While both courts found that Kentucky's AWP statutes do "relate to" and are "connected with" ERISA plans, the courts further found that Kentucky's AWP statutes fall within the savings clause, see 29 U.S.C. § 1144 (b)(2)(A), as being state laws that regulate insurance.[1] Petitioners' Appendix 1a-63a and 64a-84a.

In 1994, in an effort to reform Kentucky's healthcare market, the Kentucky General Assembly passed House Bill ("HB") 250. Kentucky's first general AWP statute was included in that bill and later codified in Ky. Rev. Stat. Ann. § 304.17A-110(3). Ky. Rev. Stat. Ann. § 304.17A-110 included other important patient protection regulatory provisions such as guaranteed renewability for eligible individuals and a pre-existing condition exclusion provision.

To further regulate the business of insurance, the General Assembly amended the Kentucky insurance code, effective July 15, 1996, to include the chiropractic AWP statute. Ky. Rev. Stat. Ann. § 304.17A-171(2); *see also*

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[1] Although the Department disagrees with the Sixth Circuit's conclusion that Ky. Rev. Stat. Ann. § 304.17A-270 and Ky. Rev. Stat. Ann. § 304.17A-171(2) "relate to" ERISA plans, this Brief in Opposition will only address the arguments raised in the Petition for a Writ of Certiorari.

Petitioners' Appendix 89a-91a. In 1996 and 1998, some of the patient protection provisions in Ky. Rev. Stat. Ann. § 304.17A-110 were amended and codified in other parts of the insurance code.

Kentucky's current general AWP statute is found at Ky. Rev. Stat. Ann. § 304.17A-270. Petitioners' Appendix 89a. In drafting the AWP statutes, the Kentucky General Assembly's clear focus was to regulate insurance and to provide additional benefits to the consumers in Kentucky, many of whom were limited to one choice of insurer in their county or geographic area.

The language in Kentucky's general AWP statute is simple. It provides that a "health insurer" may not "discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer." Ky. Rev. Stat. Ann. § 304.17A-270. *See also* Petitioners' Appendix 89a. "Insurer" is defined in subtitle 17A[2] as "any insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky." Ky. Rev. Stat. Ann. § 304.17A-005(23). *See also* Petitioners' Appendix 89a.

---

[2] Subtitle 17A governs all "health benefit plans" issued in Kentucky.

"Health benefit plan" is also defined in subtitle 17A as "any hospital or medical expense policy . . . nonprofit hospital, medical-surgical, and health service corporation contract . . . provider sponsored integrated health delivery network; a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract . . . " Ky. Rev. Stat. Ann. § 304.17A-005(18). *See also* Respondent's Appendix A.

The chiropractic AWP statute simply states that "[a] health benefit plan that includes chiropractic benefits shall . . . [p]ermit any licensed chiropractor who agrees to abide by the terms, conditions, reimbursement rates, and standards of quality of the health benefit plan to serve as a participating primary chiropractic provider to any person covered by the plan." Ky. Rev. Stat. Ann. § 304.17A-171(2); *see also* Petitioners' Appendix 89a-91a.

Petitioners, Kentucky Association of Health Plans, Inc., *et al.*, challenged the Kentucky Department of Insurance's enforcement of the AWP statutes in the United States District Court for the Eastern District of Kentucky.

Petitioners asked the District Court to find the AWP statutes unconstitutional and enjoin the Department from enforcing the statutes against any party. On cross-motions for partial summary judgment, the District Court held that the statutes are saved from ERISA preemption because they "regulate insurance." Petitioners filed an appeal with the Sixth Circuit Court of Appeals. Looking solely at the language in Kentucky's AWP statutes and applying this Court's two-part test found in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985); *see also*,

e.g., UNUM Life Ins. Co. of America v. Ward, 526 U.S. 358 (1999) (same; quoting *Metropolitan Life*), the Sixth Circuit determined that Kentucky's statutes regulate insurance within the meaning of 29 U.S.C. § 1144(b)(2)(A).[3]

First, according to the mandate in *Metropolitan Life*, a court must inquire as to whether the statute regulates insurance as a matter of "common sense." Second, *Metropolitan Life* requires a court to apply the three criteria developed under the McCarran-Ferguson Act, 15 U.S.C. § 1012(b), to determine whether a practice constitutes the "business of insurance." The three criteria are as follows: "*first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry." *Metropolitan Life*, 471 U.S. at 743 (emphasis in original).

In requesting Certiorari, Petitioners are asking this Court to find that the general concept behind an AWP statute prevents it from being a statute that regulates the "business of insurance." However, to reach this conclusion would require the Court to treat all state AWP statutes the same. That is not the Sixth Circuit's holding in this case. The Sixth Circuit correctly applied the two-part test to the specific language in Kentucky's insurance code and properly found that Kentucky's AWP laws are saved

[3] *See Kentucky Ass'n of Health Plans, Inc. v. Nichols*, 227 F.3d 352 (6th Cir. 2000) found at Petitioners' Appendix 1a-63a.

from ERISA preemption. Therefore, Certiorari is not appropriate in this case.

REASONS FOR DENYING THE WRIT

Petitioners have failed to demonstrate any compelling reason to justify granting the Petition for a Writ of Certiorari.[4] This case does not satisfy any of the criteria for the United States Supreme Court to grant review. The Sixth Circuit's decision is not in direct conflict with any precedents set by this Court and is not in direct conflict with any other Circuit Court's holding on this matter.

I. The Federal Circuits Are Not In Conflict Over The Issues Presently Before This Court.

Petitioners contend that Certiorari is warranted to address two controversies in the federal circuits. First, Petitioners maintain that there is a direct split in the circuits over whether AWP laws are preempted by ERISA. Respondent disagrees. The federal circuits have analyzed distinguishable AWP statutes and, therefore, it cannot be said that the circuits are divided on this issue. Second, Petitioners argue that there is a disagreement in principle among the circuits over the question whether laws that

[4] Respondent also filed a Brief in Opposition in *Community Health Partners, Inc., et al. v. Miller*, No. 00-1295 on April 13, 2001 addressing the same issues as in the present case.

affect the "cost component" of insurance risk satisfy the risk-transfer or risk spreading prong developed under the McCarran-Ferguson Act, 15 U.S.C. § 1012(b). Again, Respondent disagrees. The cases relied upon by Petitioners, in support of this argument, are clearly distinguishable from the present case.

A. There is No Split In The Circuits Over The Question Of Whether AWP Statutes Are Laws Which Regulate Insurance.

i. *The Eighth Circuit*

Petitioners rely on *Prudential Ins. Co. of America v. National Park Med. Ctr., Inc.*, 154 F.3d 812 (8th Cir. 1998) to argue that the circuits are divided on the issue of AWP statutes preemption. However, reliance on this case is erroneous.

In *Prudential*, the Eighth Circuit examined the Arkansas Patient Protection Act[5] and determined that it did not meet the "common sense test" as a statute that regulated insurance. As the Sixth Circuit correctly pointed out, Arkansas' Act did not meet the common sense test "because, in part, its scope included 'employers and administrators of self-insured plans.' " Petitioners' Appendix 27a. Whereas, Kentucky's AWP statutes are "directed towards and limited to health care 'insurers' " and, therefore, statutes that regulate insurance. Petitioners' Appendix 27-28a.

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[5] Ark. Code Ann. § 23-99-204(a)(3).

Unlike Arkansas' statute, Kentucky's statutes are limited to entities that assume financial risk and, therefore, are specifically directed toward the insurance industry. *See Washington Physicians Serv. Ass'n v. Gregoire*, 147 F.3d 1039, 1045 (9th Cir. 1998), *cert. denied*, 525 U.S. 1141 (1999) (finding that a Washington law was "specifically directed" toward the insurance industry, "because it operates directly on HMOs and . . . entities . . . engaged in the business of health insurance.").

ii. *The Fifth Circuit*

Next, Petitioners rely on *Texas Pharmacy Ass'n v. Prudential Ins. Co. of America*, 105 F.3d 1035 (5th Cir. 1997), *cert. denied*, 522 U.S. 820 (1997) and *Cigna Healthplan of Louisiana, Inc. v. Louisiana*, 82 F.3d 642 (5th Cir. 1996) to argue that the circuits are divided on the issue of whether AWP statutes are preempted by ERISA. Petitioners' reliance on these cases is also misplaced.

In *Texas Pharmacy Ass'n*, the Fifth Circuit found a Texas statute relating to pharmacies preempted as it did not meet the third requirement in the McCarran-Ferguson test. Specifically, the Fifth Circuit found the Texas statute did "not fall within the savings clause because it is not limited to entities within the insurance industry." *Texas Pharmacy Ass'n*, 105 F.3d at 1038. The Texas statute applied to "health maintenance organizations (HMOs), preferred provider organizations (PPOs), and other organizations that provide health care services." *Id.* The Fifth Circuit went on to state that if a self-insured employer, not subject to the Any Willing Provider statute, "signed up with an HMO or PPO, those organizations would be

subject to the statute, even if there is no insurance company involved." *Id.* at 1039.

Texas Pharmacy Ass'n is factually and legally distinguishable from the present case. First, as Petitioners concede, the Fifth Circuit did not analyze all of the factors relevant to the determination as to whether a statute "regulates insurance" for the purposes of the ERISA savings clause. Instead, the court merely analyzed the third requirement under the McCarran-Ferguson test to find the statute preempted. Thus, the court was requiring compliance with all the McCarran-Ferguson factors before it would find the statute saved from ERISA preemption. However, as the Sixth Circuit correctly noted, "the three McCarran-Ferguson factors are not required to be satisfied before a state law can be found to be a law regulating insurance." Petitioners' Appendix 38a. Because the court in *Texas Pharmacy Ass'n* failed to apply the "common sense test" and analyze the statute under all three of the McCarran-Ferguson factors, the case is legally distinguishable from the present case.

Second, the court in *Texas Pharmacy Ass'n* found that the Texas statute applied to HMOs and PPOs acting as administrators of an employer's self-funded plan. *Texas Pharmacy*, 105 F.3d at 1039. Kentucky's statutes do not function in such a manner. The Sixth Circuit correctly noted that "Kentucky statute[s] [are] directed toward and appl[y] to only insurers and not to plan administrators." Petitioners' Appendix 29a. The Department of Insurance only regulates risk-bearing entities. "A plan administrator that does nothing more than administer the plan of a self-insured employer is not engaged in 'the underwriting and spreading of risk.' " Petitioners' Appendix 29a,

quoting *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 221 (1979).

For these reasons, the Fifth Circuit's decision in *Texas Pharmacy Ass'n* is legally and factually distinguishable from the present case.

In *Cigna Healthplan of Louisiana*, the Fifth Circuit again analyzed a state statute by applying only the third factor of the McCarran-Ferguson test. In doing so, the Fifth Circuit concluded that Louisiana's statute is not limited to entities within the insurance industry and, therefore, preempted by ERISA. *Cigna Healthplan of Louisiana*, 82 F.3d at 650. The court found that "[e]ven though the statute lists insurers as one group covered by its terms, it also specifies, in a non-exclusive list, that it applies to 'self-funded organizations, Taft-Hartley trust, or employers who establish or participate in self-funded trusts or programs . . . ' " *Id.*

Again, the Fifth Circuit's decision in *Cigna Healthplan of Louisiana* is legally and factually distinguishable from the present case. First, the Fifth Circuit did not fully analyze the statute when it failed to apply the "common sense test" and the three McCarran-Ferguson factors to the statute. Instead, the court found preemption after analyzing only the third factor of the McCarran-Ferguson test. Second, Louisiana's statute is distinguishable from Kentucky's AWP statute in that it does not meet the "common sense" definition of insurance because it attempts to regulate entities clearly outside the insurance industry (*i.e.*, self-funded organizations and employers). Kentucky's AWP statute is not as far reaching. Therefore,

Petitioner's reliance on *Cigna Healthplan of Louisiana* is erroneous.

There is no conflict among the circuits. The circuits have reviewed different state statutes drafted by different state legislatures. Petitioners would have this Court believe that a state legislature could not pass AWP legislation without it being preempted by ERISA no matter what language was used. That simply is not the case. Kentucky has successfully drafted and passed AWP legislation that, as both the district court and court of appeals found, is saved from ERISA preemption.

B. The Circuits Are Not Divided Over The Substantive Content of the McCarran-Ferguson Risk-Spreading Factor

Petitioners rely on *Cisneros v. UNUM Life Ins. Co.*, 134 F.3d 939 (9th Cir. 1998), *cert. denied*, 526 U.S. 1086 (1999); *Smith v. Jefferson Pilot Life Ins. Co.*, 14 F.3d 562 (11th Cir. 1994), and *Prudential Ins. Co. of America v. National Park Med. Ctr. Inc.*, 154 F.3d 812 (8th Cir. 1998) to argue that the circuits are divided over the substantive content of the McCarran-Ferguson risk-spreading factor. Petitioners' reliance on these cases is misplaced.

First, in *Cisneros*, the Ninth Circuit determined that California's notice-prejudice rule – a rule prohibiting a denial of benefits for late-filed claims absent prejudice to the insurer – did not have the effect of transferring or spreading the policyholder's risk. The court also found that the failure of the notice-prejudice rule to meet the first prong of the McCarran-Ferguson test did not affect the earlier determination that the rule met the common-

sense view of regulating insurance. *Cisneros*, 134 F.3d at 945-946.

California's notice-prejudice rule is distinguishable from Kentucky's AWP statutes. Unlike California's rule, Kentucky's AWP statutes allow for additional coverage for the insured by providing the insured with more choice in health care providers. This shifts more of the cost of covering the care to the insurer, which may have chosen to exclude a provider's service, but for the requirements of the Any Willing Provider statute. Thus, Kentucky's AWP statutes reduce the chances the insured will have to pay out-of-pocket to access a health care provider of choice. *See Blue Cross & Blue Shield v. Bell*, 798 F.2d 1331, 1335 (10th Cir. 1986) (discussing Kansas' "mandated-provider law," the court stated that "[t]he policy determines the scope of coverage, that is, whether [the insured] has assumed the risk of the entire loss . . . The choice of a provider does not add to the insured's coverage but is of the essence of that coverage bargained for as the transferred risk"). For these reasons, Petitioners' reliance on *Cisneros* is erroneous.

Smith v. Jefferson Pilot Life Ins. Co., 14 F.3d 562 (11th Cir. 1994), *cert. denied*, 513 U.S. 808 (1994) is also distinguishable from the present case. The Eleventh Circuit in *Jefferson Pilot* considered whether a Georgia law requiring an insurer to provide written notification of termination to the insured had the effect of transferring or spreading a policyholder's risk. The Eleventh Circuit concluded that it did not. Unlike the Georgia statute at issue in *Jefferson Pilot*, Kentucky's AWP statutes place an additional risk on the insurer at the time the insured contracts with the

insurer. Georgia's statute merely placed an additional administrative duty on the insurer.

A consumer contracts with a health insurer in order to have affordable access to providers. A diverse panel of providers reduces the chances the consumer will have to seek care outside the network and, thus, increases the insurer's risk but reduces the insured's risk. For these reasons, Petitioners' reliance on *Jefferson Pilot* is misplaced.

The court in *Prudential Insurance Co. of America v. National Park Medical Center, Inc.* (8th Cir. 1998) failed to analyze the first McCarran-Ferguson factor with regard to Arkansas' Patient Protection Act. The court only concluded, without analysis, that Arkansas' Patient Protection Act did not transfer or spread the policyholder's risk. Because the court failed to analyze the first prong of the McCarran-Ferguson test, the court's conclusion in *Prudential Insurance* cannot be relied upon to support Petitioners' argument.

The Ninth Circuit and Eleventh Circuit have both considered the application of the McCarran-Ferguson risk-spreading factor. However, these circuits have applied that factor to statutes that are distinguishable from Kentucky's AWP statutes. Because the circuits have reviewed distinguishable statutes, Petitioners' argument that the circuits are divided over the substantive content of the McCarran-Ferguson risk-spreading factor is simply incorrect.

Even if it can be argued that the circuits have developed differing views of the risk-spreading factor, a division over one factor of the McCarran-Ferguson test does

not warrant this Court granting Certiorari. As the Sixth Circuit stated, "it should be emphasized, in applying the McCarran-Ferguson factors, that 'the focus of McCarran-Ferguson is upon the relationship between the insurance company and its policyholders,' and state statutes aimed at regulating that relationship, 'directly or indirectly, are laws regulating the business of insurance.' " Petitioners' Appendix 34a, citing *United States Dep't of the Treasury v. Fabe*, 508 U.S. 491, 501 (1993).

Additionally, the Sixth Circuit correctly noted that "the three . . . factors are not required to be satisfied before a state law can be found to be a law regulating insurance." Petitioners' Appendix 38a. The three factors are merely "guideposts" and the ultimate test remains whether "from a common sense view, the Kentucky AWP laws in question regulate insurance." *Id.* Kentucky's AWP statutes easily meet the common-sense view of regulating insurance. Certiorari should not be granted to review one factor of the McCarran-Ferguson test.

II. The Sixth Circuit Properly Followed All Applicable Precedents Of This Court.

Petitioners argue that the Sixth Circuit's decision contradicts this Court's precedent in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). Respondent disagrees.

Royal Drug is a 1979 antitrust case wherein this Court ruled that pharmacy provider agreements are not the "business of insurance" within the meaning of the McCarran-Ferguson Act and, therefore, are not exempt

from the antitrust laws. The pharmacy provider agreements at issue involved an insurance company's agreement with pharmacy providers to sell prescription drugs for $2.00 to the company's policyholders in exchange for reimbursement from the company for the cost of the drug. This Court held that these agreements were "merely arrangements for the purchase of goods and services" by the insurance company. *Royal Drug*, 440 U.S. at 214.

Kentucky's AWP statutes are distinguishable from the pharmacy agreements at issue in *Royal Drug*. Kentucky's AWP statutes address much more than "arrangements for the purchase of goods and services." The Kentucky General Assembly passed the AWP statutes as part of a major health insurance reform measure. The General Assembly intended to make healthcare coverage more affordable and accessible to citizens of the Commonwealth and enacted these statutes as patient protection provisions to benefit the consumer. The Kentucky General Assembly did not enact the statutes to benefit the insurance company or providers. Rather, Kentucky's AWP statutes benefit the consumer by shifting part of the cost of healthcare from the insured to the insurer. This is done by allowing consumers greater access to providers and lessening the chances that the consumer will have to pay out-of-pocket to visit a provider of choice. The Kentucky General Assembly accomplished this task with an awareness of ERISA preemption. With preemption in mind, the AWP laws were written so that it applied only to those entities engaged in the business of insurance.

The Fourth Circuit has determined that AWP statutes can indirectly affect "the insured's choice of provider and

the consequent cost to the insured if he or she deems an excluded provider to be better qualified for treatment of a specific illness or accident. In this way it affects the risk that an insured must bear." *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500, 504 (4th Cir. 1993), *cert. denied*, 510 U.S. 1003 (1993); *see also Texas Pharmacy Ass'n v. Prudential Ins. Co. of America*, 105 F.3d 1035 (5th Cir. 1997), *cert. denied*, 522 U.S. 820 (1997) (distinguishing a prior AWP statue from *Royal Drug* and concluding that the statute affects spreading of risk because it influences which costs are borne by the insurer and which are borne by the policyholder). Since Kentucky's AWP statutes function in the same manner as the AWP statute in *Stuart Circle* and the prior AWP statute in *Texas Pharmacy Association*, they are much more than "arrangements for purchase of goods and services."

Although one can argue that the agreements in *Royal Drug* did not concern the policyholder, one cannot argue the same for Kentucky's AWP statutes. Access to qualified healthcare providers through insurers is of vital concern to consumers. The Department of Insurance, the entity charged with regulating health insurers in the Commonwealth of Kentucky, confronts this basic consumer issue as part of its daily regulatory function. Therefore, the Sixth Circuit correctly stated that "[u]nlike *Royal Drug*, policyholders in Kentucky will benefit under their policies by a new change in coverage, insofar as availability of providers is concerned." Petitioners' Appendix 32a-33a.

Royal Drug involved issues of antitrust law. As the court noted in *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp 60, 72 (D. Mass. 1997), it

is not clear that the holding in *Royal Drug* can "be translated to the ERISA preemption context at all."

Petitioners have maintained at both the district court level and the circuit court level that *Royal Drug* should be the standard applied in this case. That argument has been rejected every time. Again, on Petition for a Writ of Certiorari, Petitioners have failed to present any new arguments with regard to the applicability of *Royal Drug*.

III. Petitioners' Attempt To Treat All State AWP Statutes The Same Must Fail.

Petitioners contend that Certiorari is warranted to resolve the issue of whether ERISA preempts AWP statutes. However, that is not the question before this Court. The Sixth Circuit, as did the Fourth, Fifth, and Eighth circuits, considered separate and distinct AWP statutes. Neither the Sixth Circuit, nor the other circuits, were asked to consider whether AWP statutes are "good for" the healthcare industry generally. Instead, each circuit was asked to analyze a particular state AWP statute and decide whether that AWP statute was preempted by ERISA. Each circuit decided this question by applying the test developed by this Court in *Metropolitan Life Ins. v. Massachusetts*, 471 U.S. 724 (1985) and *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358 (1999).

There is no issue of national importance. Petitioners simply want to broaden the scope of ERISA preemption because they do not like the general concept of AWP statutes. Petitioners are attempting to broaden the scope of ERISA preemption when this Court has recently narrowed ERISA preemption with regards to state regulation

that was not contemplated to fall within a broad ERISA preemption umbrella. *See New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995); *DeBuono v. N.Y.S.A. – ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997); and *California Div. of Labor Standards Enforcement v. Dillingham Const., N.A., Inc.*, 519 U.S. 316 (1997).

Certiorari is not warranted because this Court has already set forth a clear ERISA preemption test to be applied to state statutes. The test does not need to be expanded. Regardless of Petitioners' "feelings" about AWP statutes, if a statute meets the two-part test, a court must find that the statute is not preempted. The Sixth Circuit correctly applied the test to Kentucky's AWP statute and correctly found that it is not preempted by ERISA.

CONCLUSION

For the foregoing reasons, the Petition for a Writ of Certiorari should be denied.

Respectfully submitted,

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Respondent's Appendix A

KRS 304.17A-005(18)

"Health benefit plan" means any hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; provider sponsored integrated health delivery network; a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; or any health benefit plan that affects the rights of a Kentucky insured and bears a reasonable relation to Kentucky, whether delivered or issued for delivery in Kentucky, and does not include policies covering only accident, credit, dental, disability income, fixed indemnity medical expense reimbursement policy, long-term care, Medicare supplement, specified disease, vision care, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, short-term coverage, student health insurance offered by a Kentucky-licensed insurer under written contract with a university or college whose students it proposes to insure, medical expense reimbursement policies specifically designed to fill gaps in primary coverage, coinsurance, or deductibles and provided under a separate policy, certificate, or contract, or coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code;

Supreme Court, U.S.
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No. 00-1471

IN THE

Supreme Court of the United States

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., *et al.*,
Petitioners,

v.

JANIE MILLER, COMMISSIONER OF THE KENTUCKY DEPARTMENT OF INSURANCE,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

REPLY BRIEF FOR PETITIONERS

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REPLY BRIEF FOR PETITIONERS

The decision of the Sixth Circuit in this case exacerbates a split in the federal circuits, and conflicts with a decision of this Court, over a question that goes to the very heart of the continuing national debate over the use of managed care systems to bring the spiraling costs of health care delivery under some control, without risk to the quality of care provided. As the petition explains, health maintenance organizations ("HMOs") and other managed-care entities have determined that they can serve both goals simultaneously by creating limited networks of providers, whose fees are lower because of the exclusivity of their access to HMO beneficiaries, and whose care quality can be more closely monitored because of the limited network size. The problem is that many states – including Kentucky – have enacted statutes prohibiting the provider network limitations on which the cost and quality benefits depend, requiring that HMOs cast open their networks to any provider willing to meet the network terms. This case squarely presents the question whether such statutes are valid or are preempted by federal law.

Respondent does not seriously dispute the importance of the issues raised in this case. Instead, respondent seeks refuge entirely in efforts to deny the conflicts in the courts by distinguishing the decided cases. Those efforts are unavailing. At bottom, respondent's brief only confirms the sharp divisions among the courts on the important question presented here and, consequently, the urgent need for review.

I. THE CIRCUITS ARE DIVIDED OVER THE FEDERAL PREEMPTION OF AWP LAWS

As the petition demonstrates, the Sixth Circuit's decision in this case that the Kentucky AWP laws are not preempted by the Employee Retirement Income Security Act of 1974 ("ERISA") because they are not laws "which regulate insurance," 29 U.S.C. § 1144(b)(2)(A), follows a decision of the Fourth Circuit upholding a Virginia AWP law against an ER-

ISA preemption challenge, and conflicts with decisions of the Fifth and Eighth Circuits rejecting AWP laws in Louisiana, Texas and Arkansas. *See* Pet. 12-15. Respondent concedes that Kentucky's AWP laws "function in the same manner" as the Virginia statute reviewed by the Fourth Circuit in *Stuart Circle Hosp. Corp. v. Aetna Health Mgmt.*, 995 F.2d 500 (4th Cir.), *cert. denied*, 510 U.S. 1003 (1993), Resp. Br. 15, but argues that the AWP laws invalidated by the Fifth and Eighth Circuits are distinguishable. The "distinctions" on which respondent relies are, however, trivial at most, and often simply incorrect.

Attempting to distinguish the Eighth Circuit's decision in *Prudential Insurance Co. v. National Park Medical Center*, 154 F.3d 812 (8th Cir. 1998), respondent relies on the observation of the majority below that the Eighth Circuit "found that an Arkansas AWP provision did not meet the common sense test because, in part, its scope included 'employers and administrators of self-insured plans' (although the statute excluded self-funded ERISA plans)." Resp. Br. 6 (quoting Pet. App. 27a). "Unlike Arkansas' statute," respondent contends, "Kentucky's statutes are limited to entities that assume financial risk." *Id.* at 7.

That contention is baffling: Kentucky's AWP laws are not at all "limited to entities that assume financial risk," but apply to "self-insurers who are not protected by ERISA's deemer clause," as even the majority opinion below recognized. Pet. App. 26a. Indeed, contrary to respondent's assertion, the majority opinion below does not point to the application of Arkansas' AWP law to self-funded non-ERISA plans for the purpose of *distinguishing* that law, but rather to explain its *disagreement* with the Eighth Circuit's analysis of the Arkansas law. Immediately after reciting the Eighth Circuit's conclusion that the application of the Arkansas law to self-funded plans renders the law preempted (in the passage quoted by respondent), the majority opinion *rejects* the conclusion (in a passage omitted by respondent): "we do not believe that inclusion of self-insurers not protected by the deemer clause, as well as purchasers of insurance, within the statute's reach in itself removes the statute [from the saving clause]." Pet. App. 27a. The conflict between the decision below and the Eighth Circuit's decision in *Prudential Insurance* is inescapable.

Turning next to the two Fifth Circuit decisions cited in the petition, *Texas Pharmacy Association v. Prudential Insurance Co. of America*, 105 F.3d 1035 (5th Cir.), *cert. denied*, 522 U.S. 820 (1997), and *CIGNA Healthplan v. Louisiana*, 82 F.3d 642 (5th Cir.), *cert. denied*, 519 U.S. 964 (1996), respondent suggests that these decisions are "legally and factually distinguishable" from the decision below. Resp. Br. 8, 9. Respondent is wrong on both counts.

Respondent asserts that the opinions are "legally distinguishable" from the Sixth Circuit's opinion because the Fifth Circuit cases both "failed to apply the 'common sense test,'" Resp. Br. 8, 9, and instead applied only the third McCarran-Ferguson factor – *viz.*, whether the law is limited to entities within the insurance industry – to invalidate the Texas and Louisiana AWP laws. Resp. Br. 8-9. It is true that *CIGNA Healthplan* and *Texas Pharmacy* were decided before this Court made clear in *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 373 (1999), that a law need not satisfy every McCarran-Ferguson factor. But there is no basis for questioning the continuing vitality of the decisions after *UNUM*. Respondent overlooks the fact that, under this Court's precedents, a conclusion under the third McCarran-Ferguson factor that a law is not one that regulates insurance because it regulates entities outside the insurance industry "would compel the same conclusion under the common-sense [test] as well." Pet. 15-16 n.6 (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987)). More to the point, respondent also overlooks the Fifth Circuit's recent statement

of that very conclusion in *Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 215 F.3d 526 (5th Cir. 2000), *petition for cert. filed*, No. 00-665, 69 U.S.L.W. 3317 (Oct. 24, 2000), in which the court not only observed that "[t]he common sense test measures whether the law is specifically directed toward the insurance industry," *id.* at 538, but invoked that principle to reaffirm *Texas Pharmacy* and *CIGNA Healthplan*, *id.* at 538 & n.51. *See also* Pet. 15-16 n.6. *Corporate Health* simply leaves no doubt about the controlling force of *Texas Pharmacy* and *CIGNA Healthplan* in the Fifth Circuit, even after *UNUM*.

Respondent also contends that the Fifth Circuit AWP decisions are "factually distinguishable" from the decision below, in that the Louisiana and Texas AWP laws applied to non-insurance entities. Respondent attempts to distinguish the Louisiana statute at issue in *CIGNA Healthplan* on the ground that it "regulate[d] entities clearly outside the insurance industry (*i.e.*, self-funded organizations and employers)." Resp. Br. 9. But the Kentucky laws, as we have seen, *also* regulate "entities clearly outside the insurance industry" – *i.e.*, self-funded organizations and employers not governed by ERISA. Thus, on respondent's own view of the key material fact in *CIGNA Healthplan*, the analysis and result of the decision is irreconcilable with the decision below.

As to *Texas Pharmacy*, respondent merely notes that the opinion focuses primarily on the Texas law's application to "HMOs and PPOs acting as administrators of an employer's self-funded plan." Resp. Br. 8. According to respondent, Kentucky's laws are distinguishable because they do not apply to HMOs and PPOs acting only as plan administrators. *Id.* But even assuming that were true,[1] it does not suffice to

[1] In fact, the Kentucky laws apply in terms to all HMOs and PPOs, with no exemption for those engaged solely in administrative services. *See* Pet. App. 42a-43a (Kennedy, J., dissenting).

distinguish the Texas statute, which operated precisely the same as the Kentucky laws in respect to *employers*, exempting only those that were subject to ERISA, *see Texas Pharmacy*, 105 F.3d at 1037, leaving non-ERISA self-funded employers subject to its AWP requirements. Though the court did not focus on that aspect of the statute, the inclusion of such employers plainly would have been enough to hold the law preempted under Fifth Circuit law – as the court subsequently reaffirmed in *Corporate Health*. *See* 215 F.3d at 538 (state law falls outside the saving clause if it covers entities "not engaged in insurance practices," including "employers"). By contrast, the Texas statute just as plainly would *not* be preempted under the decision below, demonstrating an irreconcilable conflict between the opinions that only confirms the case, already well-established by the conflicts discussed above, for certiorari review.

It should be clear, finally, that we are not asking this Court to "treat all AWP statutes the same." Resp. Br. 16. It is inherent in the judicial power that a case may be decided only on the particular facts before the Court, and thus the circuits each have of course "considered separate and distinct AWP statutes." *Id.* But as the petition already observed, while there may be "certain differences in the wording of the AWP statutes at issue in the decided cases . . . the statutes are all essentially the same in operation and effect." Pet. 16. Respondent's failed efforts to identify any meaningful distinctions only substantiates the point. The simple fact is that Kentucky's AWP laws are in no way unusual or extreme; they are "heartland" AWP statutes, and they give this Court an ideal vehicle for resolution of the nationwide controversy over the validity of AWP laws.

II. THE CIRCUITS ARE DIVIDED OVER THE SUBSTANTIVE CONTENT OF A KEY ELEMENT IN THE SAVING CLAUSE INQUIRY

As the petition explained, this case would also provide an opportunity to resolve a conflict in the courts over an important principle that governs the ERISA preemption/saving clause inquiry – not just in the AWP context, but in every other context implicating the saving clause. Respondent misapprehends our argument on this point, and thus fails to refute either the existence of a conflict or the reason it counsels in favor of certiorari.

The argument raised in the petition was that the circuits are divided in their analysis of the first McCarran-Ferguson factor as it applies in a variety of saving clause contexts – *viz.*, whether the practice regulated has the effect of transferring or spreading an insurance policyholder's risk, which the Court has labeled "an indispensable characteristic of insurance." *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 212 (1979). The Fourth and Sixth Circuits, we explained, each took an expansive view of the meaning of "risk-spreading" in their respective AWP decisions, holding that AWP laws regulate insurance in part because they shift away from the insured the cost of care from a provider that is not included in the "insurer's" network. *See* Pet. 17. The Tenth Circuit has taken a similarly broad view in a related context, *id.*, whereas decisions by the Ninth and Eleventh Circuits in other saving clause cases have explicitly held that a law regulates the "spreading" of "risk" under this McCarran-Ferguson factor only when it affects the risk of needing care for a *particular injury*, not the cost of obtaining care from a *particular provider*, *id.* at 18.

Respondent's principal response is to argue that the Ninth and Eleventh Circuits applied their narrow analysis of the McCarran-Ferguson risk-spreading factor to non-AWP statutes "that are distinguishable from Kentucky's AWP

statutes." Resp. Br. 12; *see id.* at 10-12. But that is precisely *our* point, which respondent has missed: the disagreement in the opinions below over the critical risk-spreading factor as applied to AWP laws actually reflects a more fundamental disagreement in the courts over the substantive meaning of that factor, which has arisen in other saving clause contexts as well. The fact that a key issue implicated in the saving clause analysis of AWP laws has consequences in other contexts simply demonstrates the broader legal importance of this case. And the opportunity "to provide further guidance as to the nature of the risk-spreading factor," and to help "clarify the resolution of saving clause issues that arise in respect to a variety of state health care regulatory statutes," Pet. 19, is all the more reason the Court should address the basic AWP preemption conflict presented here.[2]

III. THE DECISION BELOW CONFLICTS WITH A DECISION OF THIS COURT

In *Royal Drug*, this Court held unambiguously that a contract between an insurer and a third-party provider was *not* part of the "the business of insurance" under the McCarran-Ferguson Act. *Royal Drug*, 440 U.S. at 214-15; *id.* at 243 (Brennan, J., dissenting). The majority opinion below applies the very same McCarran-Ferguson factors first identified in *Royal Drug*, *see Union Labor Life Ins. Co. v. Pireno*, 458 U.S 119, 129 (1982) ("*Royal Drug* identified

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[2] Respondent's only other argument on this point is that "a division over one factor of the McCarran-Ferguson test does not warrant granting certiorari," because not every factor need be met in every case. Resp. Br. 12-13. But we have not suggested that a division over one factor would be sufficient in and of itself to warrant review. Our point is simply that the importance of this case extends beyond the AWP law context, and that this case presents a potential opportunity to contribute clarity to related ERISA saving clause contexts, which are *additional* reasons why the conflict over AWP laws merits review.

three criteria relevant in determining whether a particular practice is part of the 'business of insurance'"), but reaches the opposite conclusion: that petitioners' contracts with the third-party providers *are* the "business of insurance" under McCarran-Ferguson and, consequently, Kentucky's law regulating those contracts is a law which regulates insurance.

Respondent suggests two reasons why the decision below does not conflict with *Royal Drug*. Both are meritless.

First, respondent asserts that while "one can argue that the agreements in *Royal Drug* did not concern the policyholder, one cannot argue the same for Kentucky's AWP statutes." Resp. Br. 15. This is so, respondent continues, because "[a]ccess to qualified healthcare providers through insurers is of vital concern to consumers." *Id.* That argument is a non sequitur. No matter how important consumers may think "access to qualified healthcare providers through insurers" is, that has nothing whatsoever to do with whether a law that regulates *insurers' third-party provider contracts* is a law that regulates *insurance* under McCarran-Ferguson. This Court held in *Royal Drug* that third-party provider contracts are not "the business of insurance," and neither respondent nor the majority opinion below has explained what distinguishes the third-party provider contracts at issue in *Royal Drug* from those regulated here.

Second, respondent goes so far as to suggest that because *Royal Drug* was an antitrust case under the McCarran-Ferguson Act, "it is not clear that *Royal Drug* can 'be transferred to the ERISA preemption context at all.'" Resp. Br. 15-16 (quoting *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60, 72 (D. Mass. 1997)). That argument cannot be taken seriously: it has long been settled that this Court will advert to the three McCarran-Ferguson factors in determining whether a law is one "which regulates insurance" for purposes of the ERISA preemption saving clause. *See UNUM*, 526 U.S. at 267; *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48-49 (1987). Those factors were, of course, first identified in *Royal Drug* itself. *See supra* 7-8. Inasmuch as this Court *itself* has transferred the McCarran-Ferguson principles enunciated in *Royal Drug* to the ERISA preemption context, it is simply incorrect to suggest that *Royal Drug* cannot be "transferred to the ERISA preemption context."

CONCLUSION

For the foregoing reasons, and for the reasons previously stated, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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In the Supreme Court of the United States

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., ET AL., PETITIONERS

v.

JANIE A. MILLER, COMMISSIONER, KENTUCKY DEPARTMENT OF INSURANCE

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTION PRESENTED

Whether Kentucky's "any willing provider" law, which requires each health maintenance organization (HMO) in the State to make available to its subscribers the services of any medical provider in its geographical region that agrees to the terms and conditions offered by the HMO, is saved from preemption as a law that "regulates insurance" under ERISA Section 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A).

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In the Supreme Court of the United States

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JANIE A. MILLER, COMMISSIONER, KENTUCKY DEPARTMENT OF INSURANCE

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

This brief is submitted in response to the Court's invitation to the Solicitor General to express the views of the United States.

STATEMENT

1. Kentucky's "any willing provider" (AWP) law provides:

> A health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer, including the Kentucky state Medicaid program and Medicaid partnerships.

Ky. Rev. Stat. Ann. § 304.17A-270 (Michie 2001).[1] Under the AWP law, a "health insurer" must make available to its

[1] When this suit was commenced, the AWP law applied to "health benefit plan[s]," Ky. Rev. Stat. Ann. § 304.17A-110(3) (Banks-Baldwin 1995); but in 1998, the Kentucky legislature revised the law to apply to "health insurer[s]," as quoted above. Pet. App. 5a-6a. The court of appeals addressed the validity of the law in its "present form." Pet. App. 6a.

subscribers the services of any medical provider in its geographical area that agrees to the terms and conditions offered by the HMO to providers. An "insurer" is defined as

> any insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky.

Ky. Rev. Stat. Ann. § 304.17A-005(23) (Michie 2001). Supporters of AWP laws argue that the laws make it easier for patients to have access to providers of their choice, while opponents argue that they lead to increased costs by limiting the ability of insurers to guarantee a high volume of patients to providers in return for lower charges. See Pet. App. 34a n.18.

The issue in this case is whether ERISA preempts the Kentucky AWP law. Three ERISA provisions are relevant. First, ERISA's general preemption provision, Section 514(a), 29 U.S.C. 1144(a), states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." Second, ERISA's insurance saving clause, Section 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A), provides that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." Third, ERISA's deemer clause, Section 514(b)(2)(B), 29 U.S.C. 1144(b)(2)(B), which qualifies the insurance saving clause, provides that "[n]either an employee benefit plan * * * nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer * * * for purposes of any law of any State purporting to regulate insurance companies, [and] insurance contracts."

2. Contending that ERISA preempts Kentucky's AWP law, petitioners—five health maintenance organizations (HMOs) licensed under the laws of Kentucky and a Kentucky-based non-profit association of HMOs—filed suit against the Insurance Commissioner of Kentucky in federal district court to enjoin enforcement of the law. Pet. App. 64a-65a. The district court upheld the law, ruling that, although the AWP law "relate[s] to" ERISA plans, it "regulates insurance" and is therefore saved from preemption under the insurance saving clause. *Id.* at 78a-82a.

3. A divided panel of the Sixth Circuit affirmed. Pet. App. 1a-38a. The court unanimously ruled that Kentucky's AWP law "relate[s] to" employee benefit plans under 29 U.S.C. 1144(a), because it has both a "reference to" and a "connection with" ERISA plans. The panel concluded that, because the AWP law applies to a "self-insured plan * * * *to the extent permitted by ERISA*," Ky. Rev. Stat. Ann. § 304.17A-005(23) (Michie 2001) (emphasis added), it refers to ERISA plans. See Pet. App. 10a-11a. The court further held that AWP laws have a "connection with" ERISA plans, because they "affect the benefits available by increasing the potential providers, [and] they directly affect the administration of the plans," *id.* at 19a.

Like the district court, however, the panel majority ruled that the AWP law is saved from preemption as a law that "regulates insurance." Applying the analytical framework, of *UNUM Life Ins. Co. of Am.* v. *Ward*, 526 U.S. 358, 367-368, 373 (1999), the court first found that the AWP law is specifically directed at the insurance industry, thus satisfying the common-sense test for insurance regulation. Pet. App. 22a-24a. The court observed that "[t]he fact that it includes within its reach HMOs as well as traditional insurance companies does not take it out of the realm of insurance regulation," because "[i]n the end, HMOs function the same way as a traditional health insurer: The policyholder pays a fee for a promise of medical services in the event that he

should need them." *Id.* at 22a-23a. The court similarly held that the law's coverage of certain self-insured government and church plans (which are exempt from ERISA, see 29 U.S.C. 1003(b) (1994 & Supp. V 1999) and thus not protected from state insurance regulation by the "deemer clause," 29 U.S.C. 1144(b)(2)(B)) does not preclude a finding that the law "regulate[s] insurance," because "it is * * * within the authority of a state in enacting laws dealing with insurance to include within such laws entities that act as self-insurers." Pet. App. 24a; see *id.* at 24a-29a. Observing that the AWP law increases benefits by giving the insured more freedom to choose and is part of "a comprehensive subtitle of Kentucky's insurance code regulating health benefit plans," the court concluded that the law "clearly" satisfies the common-sense test. *Id.* at 30a. The court also held that the Kentucky law does not apply to non-insurers engaged solely in plan administration, observing that the Kentucky law "eliminate[s] any ambiguity as to whether administrators under contracts with benefit plans are included within the scope of the statutes. They obviously are not." *Id.* at 28a n.14.

The court also followed *UNUM* in considering the three factors utilized in determining whether a particular practice constitutes the "business of insurance" for purposes of the McCarran-Ferguson Act, 15 U.S.C. 1012(b). See *UNUM*, 526 U.S. at 373-375. First, the court concluded that the AWP law "spreads the cost component of the policyholder's risk among all the insureds, instead of requiring the policyholder to shoulder all or part of this cost when seeking care or treatment from an excluded doctor or hospital of his or her choice." Pet. App. 31a. The court also found that the AWP laws "directly impact the insurer-insured relationship because they affect restrictions on the network of providers available for treatment under the plan and they directly affect the administration of the plan * * * by expanding covered treatment from a closed pool of providers to an open pool of providers." *Id.* at 36a. Finally, the court reiterated

that, because the Kentucky law does not apply to entities outside the insurance business, it is directed at insurance and thus satisfies the third factor. *Id.* at 36a-37a.

Judge Kennedy dissented from the court's holding that the AWP law "regulates insurance" and is therefore saved from preemption. Pet. App. 39a-63a. In her view, the AWP law fails the common-sense test and the three McCarran-Ferguson Act factors. With respect to the common-sense test, she stated that the law "clearly target[s] more than just members of the insurance industry," because in her view it "appl[ies] to non-ERISA covered self-insured plans," *id.* at 40a-41a, and to "third parties that a self-insured ERISA plan hires to administer its plan benefits," *id.* at 42a, which she viewed as outside the insurance industry. As to the three McCarran-Ferguson factors, Judge Kennedy concluded that the AWP law does not spread risk because "[t]he risk assumed by the benefit plan under its policy, that the policyholder will require medical treatment, remains unaltered" by the AWP law. *Id.* at 50a. She concluded that the AWP law neither changes the relationship between the insurer and the insured nor is integral to it, because it "center[s] on the insurer-provider relationship," *id.* at 58a, and "leave[s] the contract terms between the insurer and insured, unaltered," *id.* at 59a. Finally, she concluded that the AWP law is not "limited to entities within the insurance industry" because the AWP law "not only regulates entities that fall outside the traditional definition of insurer," but also "extends to include entities in no way involved in underwriting risks," such as HMOs that administer ERISA-exempt self-insured plans. *Id.* at 59a.

DISCUSSION

The court of appeals correctly held that ERISA does not preempt Kentucky's AWP law. The law "relates to" employee benefits plans by indirectly but substantially affecting their content, but is saved from preemption because it is a

law that regulates insurance. Nonetheless, further review is warranted because the case presents an important and recurring issue that has caused substantial confusion and widely varying results in the courts of appeals. The issue in this case is, however, related to the issue pending before the Court in *Rush Prudential HMO* v. *Moran*, No. 00-1021. We therefore suggest that the Court hold the petition in this case and then dispose of it as appropriate in light of its decision in *Rush*.

A. Any Willing Provider Laws "Relate To" ERISA Plans

Under Section 514(a) of ERISA, 29 U.S.C. 1144(a), the provisions of ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." This provision is "clearly expansive." *Egelhoff* v. *Egelhoff*, 121 S. Ct. 1322, 1327 (2001). It "yield[s] a two-part inquiry: A law 'relate[s] to' a covered employee benefit plan for purposes of § 514(a) 'if it [1] has a connection with or [2] reference to such a plan.'" *California Div. of Labor Standards Enforcement* v. *Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 324 (1997) (citation and internal quotation marks omitted).

1. Although the Kentucky AWP law makes a literal reference to the ERISA *statute*, the court of appeals erred in holding that the law makes a forbidden "reference to" ERISA *plans*, as this Court has used that phrase. By its terms the AWP law applies to any "insurer," including any "self-insurer or multiple employer welfare arrangement *not exempt from state regulation by ERISA*." Ky. Rev. Stat. Ann. § 304.17A-005(23) (Michie 2001) (emphasis added). That reference to the ERISA statute neither singles out ERISA plans for differing treatment, *Mackey* v. *Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 830 (1988), nor is dependent on such plans for its operation, *District of Columbia* v. *Greater Washington Board of Trade*, 506 U.S. 125, 130-131 (1992). Rather, it simply acknowledges the

limits on the scope of state laws imposed by the "deemer clause" of ERISA, Section 514(b)(2)(B), 29 U.S.C. 1144(b)(2)(B), which prevents the States from regulating self-insured plans under the guise of regulating insurance. *FMC Corp.* v. *Holliday*, 498 U.S. 52, 61 (1990). The Kentucky AWP law thus treats all insurers and all plans (ERISA and non-ERISA) alike, to the extent permitted by federal law. If such a citation to ERISA itself were sufficient to warrant preemption, it would create the perverse result that a state law's express recognition of the limits imposed by federal law would render the state law preempted, not only to the extent acknowledged by that reference, but in other areas that the States concededly may regulate consistent with ERISA.

2. The court of appeals was correct, however, in holding that the AWP law falls within the scope of ERISA's express preemption provision because it has a "connection with" ERISA plans. A state law has such a connection if it "mandate[s] employee benefit structures or their administration." *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 658 (1995); see *Dillingham*, 519 U.S. at 328. The AWP law requires that insurers offer to all who purchase their policies, including ERISA plans and their participants and beneficiaries, open-panel provider networks (*i.e.*, those in which the insurer may not limit the universe of available providers) rather than closed, exclusive networks. Participants and beneficiaries of ERISA plans therefore have a wider choice of providers than they would have without the law. Accordingly, the AWP law "relates to" ERISA plans for the same reasons that other mandated-benefits laws do. See *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 739 (1985) (assuming that law requiring minimum mental health benefits relates to ERISA plans); *Travelers*, 514 U.S. at 663-664 (discussing *Metropolitan Life*); *Shaw* v. *Delta Air Lines*,

Inc., 463 U.S. 85, 97 (1983) (law requiring pregnancy benefits relates to ERISA plans).[2]

B. AWP Laws Are Saved By ERISA's Insurance Saving Clause

The court of appeals correctly held that Kentucky's AWP law is saved from preemption as a law that "regulates insurance" under 29 U.S.C. 1144(b)(2)(A). In deciding whether a state law is saved under that clause, the Court first asks "whether, from a 'common-sense view of the matter,' the contested prescription regulates insurance." *UNUM*, 526 U.S. at 367-368. To satisfy the common-sense test, a "law must not just have an impact on the insurance industry, but must be specifically directed toward that industry." *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 50 (1987); see *UNUM*, 526 U.S. at 368. Thus, a general state tort or contract law that includes the insurance industry within its reach, but is not specifically directed at it, does not "regulate insurance" and therefore is not within the saving clause. *Pilot Life*, 481 U.S. at 50, 57. Here, as the court below concluded, the AWP law makes clear on its face that it is targeted at the insurance industry. In reviewing that determination, this Court does not "normally disturb an appeals court's judgment on an issue so heavily dependent on analysis of state law." *UNUM*, 526 U.S. at 368.

1. The court below correctly ruled that the AWP law satisfies the common-sense test because it is specifically directed at insurance. By its terms, the AWP law applies to "health insurer[s]." Pet. App. 89a. It defines health insurers

[2] The direct impact of the AWP law's mandatory open-panel provider networks on plans' benefit structures and the ability of plans to operate uniformly across state lines contrasts with the incidental economic impact of state laws of general applicability that are not sufficiently connected to ERISA plans to meet the "relates to" requirement. See *Travelers*, 514 U.S. at 668; see also *De Buono* v. *NYSA-ILA Med. & Clinical Serv. Fund*, 520 U.S. 806, 815-816 (1997); *Dillingham*, 519 U.S. at 334; *Mackey*, 486 U.S. at 831-836.

to include not only traditional health insurers, but also entities that take more innovative approaches to insurance and the provision of health care, such as a "health maintenance organization" or a provider-sponsored "health service corporation." Ky. Rev. Stat. Ann. § 304.17A-005(23) (Michie 2001). HMOs may play several roles in relation to a health benefit plan, but one role—and the one covered by the Kentucky law—is that of insurer. As this Court has recognized, such organizations are "risk-bearing organizations," because they generally "assume[] the financial risk of providing the benefits promised." *Pegram* v. *Herdrich*, 530 U.S. 211, 218-219 (2000); see also Pet. App. 22a-23a; U.S. Amicus Br. at 13-16, *Rush Prudential*, No. 00-1021.[3] Indeed, millions of employees in the United States are offered the choice between indemnity health insurance plans and HMO membership as similar ways to obtain health insurance coverage. Accordingly, the application of the Kentucky law to HMOs as well as traditional insurers does not detract

[3] Like the dissent below, some courts of appeals have suggested that HMOs are not engaged in insurance for purposes of ERISA's insurance saving clause. Pet. App. 41a n.3. See also *Prudential Ins. Co. of Am.* v. *National Park Med. Ctr., Inc.*, 154 F.3d 812, 829 (8th Cir. 1998); *Texas Pharmacy Ass'n* v. *Prudential Ins. Co. of Am.*, 105 F.3d 1035, 1038-1039 (5th Cir.), cert. denied, 522 U.S. 820 (1997). The continued validity of those decisions, however, was undermined by this Court's discussion in *Pegram*. More recent decisions from those same courts recognize that HMOs may be classified as insurers for ERISA purposes. See *Corporate Health Ins., Inc.* v. *Texas Dep't of Ins.*, 215 F.3d 526, 538 (5th Cir. 2000) ("A statute may regulate insurance if it applies to insurers, health care service contractors, and HMOs."), petition for cert. pending, No. 00-665; *Express Scripts, Inc.* v. *Wenzel*, 262 F.3d 829, 836 (8th Cir. 2001) ("The language of the statutes was specifically directed at HMOs and we conclude that the provisions regulate insurance under the common sense test."); see also 29 U.S.C. 1144(b)(2)(B) (protecting self-insured plans from application of state insurance laws saved by 29 U.S.C. 1144(b)(2)(A) by barring plans from being deemed to be "an insurance company *or other insurer*" for purposes of such state laws) (emphasis added).

from the law's basic character as one that regulates "insurance."[4]

Nor does the inclusion of self-insured plans, including governmental or church plans, take the AWP law outside the insurance saving clause. Governmental and church plans are exempt from ERISA, 29 U.S.C. 1003(b) (1994 & Supp. V 1999), regardless of whether they are self-insured. Moreover, a State may reasonably conclude that "a party who has not purchased insurance, effectively act[s] as its own insurer," and States may therefore regulate self-insuring entities as part of their regulation of insurance. Pet. App. 24a; see *General Elec. Co.* v. *Gilbert*, 429 U.S. 125, 138 n.16 (1976) ("That General Electric self-insures does not change the fact that it is, in effect, acting as an insurer."). Indeed, ERISA's deemer clause, 29 U.S.C. 1144(b)(2)(B), necessarily presumes that self-insured entities are subject to state insurance regulations. The precise function of the clause is to exempt self-insured plans from state laws that would otherwise apply to them through operation of ERISA's insurance saving clause. See *FMC*, 498 U.S. at 61 ("We read the deemer clause to exempt self-funded ERISA plans from state laws that 'regulat[e] insurance' within the meaning of the saving clause."). *UNUM*, 526 U.S. at 367 n.2 (deemer clause is a "limitation on state regulatory authority"). That exemption would be unnecessary—and the deemer clause

[4] Judge Kennedy observed that such entities may in some instances merely "handle paperwork and plan administration for a self-funded [*i.e.*, self-insured] ERISA plan." Pet. App. 43a. She noted that in such cases, "[t]he only risk underwritten is that accepted by the ERISA self-insured plan, which under the 'deemer clause' of ERISA * * * cannot be treated as an insurance company for the purposes of state regulation." *Id.* at 44a. The majority, however, expressly addressed whether HMOs and similar entities acting solely as plan administrators for self-insured plans "are included within the scope of the" AWP law and concluded that they "obviously are not." *Id.* at 28a n.14. Cf. *Corporate Health Ins., Inc.*, 215 F.3d at 538 (administrators function as insurers in making benefit determinations).

superfluous—if the fact that a state law regulates self-insurance meant that the state law does not "regulate[] insurance."

This Court recognized as much in *Metropolitan Life*. There, the Court held that the state mandated-benefits law was a law that regulated "insurance" within the meaning of the saving clause, even though it included self-insured plans among the insurers within its scope. See 471 U.S. at 735-736 n.14, 740-747. Notwithstanding that intended scope, the Court simply held that, because of the "deemer clause," the mandated-benefits law did not *apply* to self-insured plans covered by ERISA. See *id.* at 735-736 n.14. The Court did not hold that the inclusion of self-insured plans made the law one that does not regulate insurance.

2. Consideration of the three McCarran-Ferguson factors, insofar as they bear on the ERISA analysis, confirms the conclusion that the Kentucky AWP law "regulates insurance." At least the last two of those factors are satisfied here. As the court below correctly concluded (Pet. App. 35a-36a), the AWP law "serves as 'an integral part of the policy relationship between the insurer and the insured.'" *UNUM*, 526 U.S. at 374; *Stuart Circle Hosp. Corp.* v. *Aetna Health Mgmt.*, 995 F.2d 500, 503 (4th Cir.) (regulations governing treatment and cost are integral parts of insurer-insured relationship), cert. denied, 510 U.S. 1003 (1993). Like other mandated-benefit provisions, the AWP law's mandate of open networks fundamentally changes the underlying insurance promise between the insurer and insured. See *Metropolitan Life*, 471 U.S. at 744 (state regulation affecting "*the type of policy which could be issued*" is part of "the core of the 'business of insurance'"); see also *UNUM*, 526 U.S. at 374 (notice-prejudice rule integral to relationship by changing bargain between insurer and insured); *Texas Pharmacy*, 105 F.3d at 1041. The AWP law, although not mandating coverage of specific conditions like the mandated coverage of mental illnesses in *Metropolitan Life* nevertheless defines

the scope of the benefits provided and mandates the type of policy that may be issued.

Likewise, for essentially the same reasons that the AWP law regulates insurance as a matter of common-sense, see pp. 8-11, *supra*, the court of appeals correctly held that the law satisfies the third McCarran-Ferguson factor in this context because the law is properly construed as limited to regulating insurers and entities acting as insurers.[5] This Court does not "normally disturb an appeals court's judgment on an issue so heavily dependent on analysis of state law," *UNUM*, 526 U.S. at 368. As in *UNUM*, the Court "lack[s] cause" to do so here, because the court of appeals' construction is reasonable. See Pet. App. 23a-29a.[6]

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[5] Neither petitioners, the court of appeals, nor any of the appellate decisions cited by petitioners, see Pet. 15-16, have asserted that AWP laws fail to satisfy the third factor because those laws regulate relations between insurers and other entities (health care providers) that are not insurers. See *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205, 231 (1979). In applying the ERISA saving clause, that point is more appropriately considered here under the second factor, as discussed in the text, because the fact that the AWP law regulates the relationship between the insurer and providers does not detract from the fact that it *also* regulates the relationship between the insurer and the insured, and therefore "regulates insurance." That does not mean, however, that the relationship between an insurer and a provider is itself the "business of insurance" for purposes of the McCarran-Ferguson Act's exemption from the antitrust laws. See pp. 15-16 & n.8, *infra*.

[6] The application of the third factor to laws that regulate self-insurers in the ERISA context may also differ from the application of that factor to the practice of self-insurers in the antitrust context. See note 8, *infra*. The ultimate statutory test for whether a state law is saved under ERISA is whether it "regulates insurance." 29 U.S.C. 1144(b)(2)(A). The ultimate statutory test in the antitrust context is different. There, the McCarran-Ferguson Act exempts a practice from the federal antitrust laws if it constitutes "*the business of* insurance." 15 U.S.C. 1012(b) (emphasis added). A self-insurer may reasonably be viewed as engaged in "insurance," and therefore a law regulating self-insurers "regulates insurance" under the ERISA saving clause. But a self-insurer would not appear to be involved in "the business of insurance" within the meaning of the McCarran-Ferguson Act.

Thus, at least two of the three McCarran-Ferguson Act factors, plus the common-sense test, are satisfied. That is sufficient to support the court of appeals' holding that Kentucky's AWP law is not preempted. See *UNUM*, 526 U.S. at 374. The court of appeals ruled that the AWP law also satisfies the first, risk-spreading factor because it has the effect of spreading the insureds' risk by providing them with more physicians to choose from and thereby reducing the likelihood that they will receive medical care outside the network and personally shoulder the cost of treatment. Pet. App. 31a; accord *Stuart Circle*, 995 F.2d at 503; see also *Express Scripts*, 262 F.3d at 838 (law preventing HMOs from making mail-order pharmacies exclusive providers transferred risk by enabling insured to avoid paying higher price at retail pharmacy when mail-order pharmacy delays filling prescription); *Texas Pharmacy*, 105 F.3d at 1041-1042; *Blue Cross & Blue Shield* v. *Bell*, 798 F.2d 1331, 1334-1335 (10th Cir. 1986).[7] But even if that conclusion is based on too broad a view of the risk-spreading factor, the McCarran-Ferguson factors are not necessary conditions for determining whether a law regulates insurance under ERISA's insurance saving clause. See *UNUM*, 526 U.S. at 373-374; see p. 16, *infra*. Thus, the court of appeals' ultimate conclusion that the

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[7] Petitioners correctly note (Pet. 17-19) that the courts of appeals on occasion have narrowly interpreted the McCarran-Ferguson "risk-spreading" criterion as "refer[ring] to the risk of injury for which the insurance company contractually agreed to compensate the insured." *Cisneros* v. *UNUM Life Ins. Co. of Am.*, 134 F.3d 939, 945-946 (9th Cir. 1998), cert. denied, 526 U.S. 1086 (1999); see Pet. App. 48a-57a (Kennedy, J., dissenting). That narrow view of risk-spreading under ERISA is incorrect. See *UNUM*, 526 U.S. at 374 (describing criterion as "whether the rule at issue 'has the effect of transferring or spreading a *policyholder's* risk' ") (quoting *Metropolitan Life*, 471 U.S. at 743) (emphasis added); cf *Department of Treasury* v. *Fabe*, 508 U.S. 491, 502-504 (1993) (under first clause of § 2(b) of McCarran-Ferguson Act, Ohio creditor-priority scheme met risk-transfer criterion by ensuring payment of policyholders' claims and performance of insurance contract).

Kentucky AWP law comes within the insurance saving clause is correct.

3. Contrary to petitioners' contention (Pet. 19-23), the decision of the court of appeals does not conflict with this Court's decision in *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1979), which held that an arrangement between insurers and pharmacists was not exempt from the federal antitrust laws under Section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. 1012(b). The insurer in *Royal Drug* entered into agreements with participating pharmacies, whereby policyholders could purchase drugs from the pharmacy for two dollars and the insurer would reimburse the pharmacy for the actual costs of the drugs purchased. Although the insurer offered that arrangement to all pharmacies, not all pharmacies chose to participate on those terms. 440 U.S. at 209. The Court held that the agreements satisfied none of the McCarran-Ferguson Act factors, and that they therefore were not exempt from the federal antitrust laws. The Court reasoned that the insurer's policyholders were "basically unconcerned with arrangements made between [the insurer] and participating pharmacies." *Id.* at 214. Characterizing the agreements as "merely arrangements for the purchase of goods and services by [the insurer]," *ibid.*, the Court held that they did not spread risk, were not central to the insurer-insured relationship, and extended to entities outside the insurance industry, *id.* at 214, 216, 231-233.

In contrast to the private agreements at issue in *Royal Drug*, state AWP laws do not merely set the rate at which an insurer will reimburse a provider who already is part of the provider network—a matter with which the policyholders in *Royal Drug* were "basically unconcerned." See also *Union Labor Life Ins. Co.* v. *Pireno*, 458 U.S. 119, 132 (1982) (policyholder's "only concern is *whether* his claim is paid") (emphasis added). AWP laws regulate who may be included in that network to begin with. Pet. App. 32a. Thus,

although such laws affect persons other than the insurer and the insured, they do so by inviting them into the provider network that the insurer makes available to the insured. In that respect, AWP and similar laws affect the nature of the insurer's underlying promise to the insured by changing the network of providers available to the insured from a limited, closed one to an open one. See *UNUM*, 526 U.S. at 374; see also Pet. App. 31a; *Express Scripts*, 262 F.3d at 837-838; *Texas Pharmacy*, 105 F.3d at 1041. Although policyholders are likely not to be directly concerned with the insurer's costs of providing benefits (as in *Royal Drug*), they are likely to be very concerned with the range of providers available to them under the plan (and therefore the likelihood that the "family doctor" is covered by the plan). Access to health care is a key element of the relationship between insurer and insured. AWP laws therefore "regulate insurance" within the meaning of ERISA's insurance saving clause. Pet. App. 33a-34a; *Texas Pharmacy*, 105 F.3d at 1041.[8]

More generally, although *Royal Drug* is informative in the ERISA context, it was not itself an ERISA case and does not control the ERISA analysis. *Royal Drug* involved the application of the second clause of Section 2(b) of the McCarran Ferguson Act, which is an exemption to the federal antitrust laws and, as such, must be construed narrowly. See *Pireno*, 458 U.S. at 126; *Royal Drug*, 440 U.S. at 231. ERISA's saving clause, by contrast, is not an exemption subject to a narrow construction, but a preservation of state authority. Cf. *Metropolitan Life*, 471 U.S. at 741 ("[t]he

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[8] Although the Kentucky AWP law's effect on the insurer-insured relationship is sufficient to bring that law within the scope of ERISA's insurance saving clause, which is designed to preserve the *broad* authority of the States over insurance, it does not follow that private conduct by an insurer affecting a provider's ability to participate in the insurer's provider network would be protected by the McCarran-Ferguson Act's *narrow* exemption from the antitrust laws simply because that conduct might also have an effect on the insurer-insured relationship.

presumption is against pre-emption"). In that regard, the saving clause bears a greater resemblance to the first clause of Section 2(b), which preserves state laws "enacted * * * for the purpose of regulating the business of insurance," 15 U.S.C. 1012(b), and "was intended to further Congress's primary directive of granting the States broad regulatory authority over the business of insurance." *Department of Treasury* v. *Fabe*, 508 U.S. 491, 505 (1993). The ERISA saving clause thus has a broader scope than the narrow exemption from the antitrust laws at issue in *Royal Drug*. See *ibid.*

Furthermore, the language of the ERISA insurance saving clause, which saves "any law of any State which *regulates insurance*," 29 U.S.C. 1144(b)(2)(A) (emphasis added), is broader than the language of the first clause of Section 2(b) of the McCarran-Ferguson Act, which applies to state laws enacted for the purpose of regulating "*the business of* insurance." 15 U.S.C. 1012(b) (emphasis added). Although the Court simply applies the three McCarran-Ferguson Act factors in determining the scope of the second clause (the antitrust exemption) in Section 2(b) of that Act, see *Pireno*, 458 U.S. at 129-134, and likewise applies those same factors (albeit perhaps more flexibly) under the first clause of Section 2(b) (the preservation of state authority) at issue in *Fabe*, see 508 U.S. at 502-504, the Court has adopted a different analysis under the ERISA insurance saving clause. In the ERISA analysis, the Court first and foremost applies a "common-sense view of the matter," *UNUM*, 526 U.S. at 367, and only then considers the McCarran-Ferguson factors, which in any event are merely "relevant" but not "required" in assessing whether a state law "regulates insurance" under ERISA. *Id.* at 373. See also *id.* at 374 (factors are "guideposts"); *FMC*, 498 U.S. at 60-61 (finding that a law "regulates insurance" under ERISA without mention of McCarran-Ferguson factors). See also note 6, *supra*. Thus, even if the Kentucky AWP law would fail *Royal Drug* scrutiny under

the McCarran-Ferguson Act, the court of appeals' decision that the AWP law satisfies the ERISA insurance saving clause would remain sound.

C. The Issue Of Whether ERISA Preempts AWP Laws Merits Further Review, Although The Court May Wish To Hold This Case Pending Its Decision In *Rush Prudential HMO* v. *Moran*

1. The decision in this case appears to conflict with decisions of two other courts of appeals holding similar state AWP statutes to be preempted. The Eighth and Fifth Circuits have held that AWP-type laws are not preempted if they apply only to traditional insurance companies, see *Texas Pharmacy*, 105 F.3d at 1040 (ruling on pre-1995 state law), and HMOs, see *Express Scripts*, 262 F.3d at 836-837, but that such laws are preempted if their definitions of covered entities also include self-insured plans (and, perhaps, third-party administrators for such plans, though that is unclear from the decisions). See *Prudential*, 154 F.3d at 829; *Texas Pharmacy Ass'n*, 105 F.3d at 1038-1040 (ruling on state law enacted in 1995); *CIGNA Healthplan of La., Inc.* v. *Louisiana*, 82 F.3d 642, 650 (5th Cir.), cert. denied, 519 U.S. 964 (1996). Although the Fifth Circuit's decisions holding such laws to be preempted have rested at least in part on misconceptions of the law that have since been clarified, the Fifth Circuit appears to adhere to those decisions.[9] See

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[9] For instance, in *Texas Pharmacy*, the Fifth Circuit rested its decision in part on the proposition that HMOs and similar entities are not part of the insurance industry, 105 F.3d at 1038-1039, but this Court has determined otherwise. *Pegram*, 530 U.S. at 218-223. Following *Pegram*, the Fifth Circuit broadened its view. See note 3, *supra*. Furthermore, in *Texas Pharmacy* and *CIGNA Healthplan*, 82 F.3d at 650, the Fifth Circuit required the laws to satisfy both the common-sense test and all three McCarran-Ferguson factors to be saved as an insurance regulation. 105 F.3d 1038. This Court, however, has expressly rejected that requirement, holding that the McCarran-Ferguson factors are merely "guideposts" in the analysis and that a law may "regulate insurance" under ERISA without satisfying all three factors. *UNUM*, 526 U.S. at 373-374. In

generally *Corporate Health.*, 215 F.3d at 538 (attempting to harmonize Fifth Circuit case law).

Under the Eighth and Fifth Circuit decisions, the Kentucky law at issue in this case would have been held to be preempted. It has a broad coverage provision that extends to a number of self-insured entities, such as "any self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association or nonprofit hospital, medical-surgical, dental, or health service corporation." Ky. Rev. Stat. Ann. § 304.17A-005(23) (Michie 2001). To be sure, the Kentucky law excludes self-insured plans that are covered by ERISA and protected from state insurance regulation by ERISA's "deemer clause," because it covers only self-insured plans "not exempt from state regulation by ERISA." But that feature could not save the Kentucky law under the Eighth Circuit's analysis. Although the Arkansas AWP law at issue in *Prudential* similarly excluded such plans, see 154 F.3d at 816 (reciting Arkansas AWP provision stating that AWP law "shall not apply to self-funded or other health benefit plans that are exempt from state regulations by virtue of [ERISA]"), the Eighth Circuit's holding in *Prudential* that the Arkansas law was preempted rested on the premise that the Arkansas AWP law covered some self-insured entities. See *Express Scripts*, 262 F.3d at 836-837 (distinguishing *Prudential*). Because the Kentucky law likewise appears to cover the same self-insured entities—*i.e.*, those, like church and government plans, that are not covered by ERISA—it would thus be preempted under the Eighth Circuit's analysis. It likewise would be preempted under Fifth Circuit precedent. See *Corporate Health*, 215 F.3d at 538 & n.51; compare *Stuart Circle* (holding that Virginia law that apparently applied to self-insured entities is saved by insurance saving clause).

Corporate Health, the Fifth Circuit acknowledged that clarification, but reaffirmed the basic holding that AWP laws are preempted to the extent they regulate entities other than traditional insurers and HMOs. 215 F.3d at 537.

2. The issue that has caused the conflict in the circuits, as well as the accompanying difficulty the courts have had in analyzing AWP laws, is important. The wisdom of AWP legislation can certainly be debated. Pet. App. 34a n.18; see also *Pegram*, 530 U.S. at 221 (structure of HMOs involves "complicated factfinding and such a debatable social judgment" not usually left to courts). But whatever its wisdom, approximately twenty-five States have enacted some form of AWP law. William J. Bahr, Comments, *Although Offering More Freedom to Choose, "Any Willing Provider" Legislation is the Wrong Choice*, 45 U. Kan. L. Rev. 557, 568 n.112 (1997). Managed-care entities subject to the strictures of those laws deliver a substantial portion of health services nationwide. It is important that the permissible scope and limits of state authority in this area be defined. Further review is therefore warranted.

3. The question presented by this case is related to the question in *Rush Prudential HMO, Inc.* v. *Moran*, No. 00-1021, cert. granted (June 29, 2001). The question there is whether ERISA preempts an Illinois law requiring HMOs to provide independent review by an outside physician in the event of a disagreement regarding whether a particular treatment is medically necessary and therefore included in the insurance coverage provided by the HMO. The court of appeals in *Rush Prudential* held that the state independent review law is saved from preemption by ERISA's insurance saving clause. Citing the Eighth Circuit's decision in *Prudential* and the Fifth Circuit's decision in *Texas Pharmacy*, the petitioner in *Rush Prudential* argues that the Illinois law does not "regulate[] insurance" because it is directed at HMOs, which in the petitioner's view do not necessarily offer insurance products and "do not always bear the risk for the

health plans with which they contract." 00-1021 Pet. Br. at 37, 39-40.[10] If the court addresses that question, its analysis may well affect the issue in this case. If so, this case should then be remanded to the court of appeals for further consideration in light of the Court's decision in *Rush Prudential*. If the decision in *Rush Prudential* does not address the insurance saving clause in a way that sheds light on this case, the Court should grant plenary review in this case at that time.

CONCLUSION

The Court should hold the petition for a writ of certiorari in this case pending its decision in *Rush Prudential HMO, Inc.* v. *Moran*, No. 00-1021, cert. granted (June 29, 2001), and then dispose of it accordingly.

Respectfully submitted.

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[10] The petitioner also argues that, under the Court's decision in *Pilot Life*, 481 U.S. at 53-57, the Illinois law conflicts with the provision in Section 502(a) of ERISA for bringing civil actions to recover benefits or enforce the terms of the plan. See 00-1021 Pet. Br. at 19-32, *Rush Prudential, supra*.

* The Solicitor General is recused in this case.

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IN THE

Supreme Court of the United States

Community Health Partners, et al.,
Petitioners,

v.

Commonwealth of Kentucky, et al.,
Respondents.

Kentucky Association of Health Plans, et al.,
Petitioners,

v.

Commonwealth of Kentucky, et al.,
Respondents.

On Petitions for Writs of Certiorari
to the United States Court of Appeals
for the Sixth Circuit

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SUPPLEMENTAL BRIEF FOR THE PETITIONERS

Petitioners respectfully submit this supplemental brief in light of this Court's decision in *Rush Prudential HMO* v. *Moran* (June 20, 2002) (No. 00-1021) ("*Rush Prudential*").

The petitions for certiorari in these cases present the Court with the opportunity to resolve the entrenched circuit conflict over whether state "any willing provider" ("AWP") statutes are preempted by ERISA. AWP laws require health benefit plans to admit any provider willing to abide by the plans' terms. Such statutes prohibit the selective provider networks that permit HMOs to reduce costs while ensuring quality care. Because the question presented turns on the meaning of ERISA's insurance "saving clause" (29 U.S.C. 1144(b)(2)(A)), this Court held these petitions pending its decision in *Rush Prudential*.

Because this Court's ruling in *Rush Prudential* will not provide the lower courts with any substantial guidance on how to resolve the question presented, certiorari should now be granted. The circuit conflict at issue – principally between decisions of the Fourth and Sixth Circuits sustaining AWP statutes and the Fifth and Eighth Circuits holding them preempted by ERISA – turns on a disagreement about whether the saving clause applies to agreements between insurers and third-party providers.

Courts that invalidate AWP laws have concluded that provider agreements are not a part of the insurance relationship. Thus, the Eighth Circuit rejects the argument that AWP statutes affect "an integral part of the policy relationship" between insurer and insured. Rather, at most, such statutes "might be an integral part of the relationship between the insurer and a third party to the insured-insurer relationship, the health care provider." *Prudential Ins. Co. of Am.* v. *National Park Med. Ctr.*, 154 F.3d 812, 829 (1998). In reaching that conclusion, the Eighth Circuit relied heavily on this Court's holding in *Group Life & Health Insurance Co.* v. *Royal Drug*,

440 U.S. 205 (1979) ("*Royal Drug*"), that provider contracts do not constitute the "business of insurance." By contrast, circuits sustaining AWP statutes concede the factual predicate underlying that conclusion – *i.e.*, that "AWP laws do not change the substantive terms of the insurance coverage" (Pet. App. 66a (decision below)) – but disagree fundamentally about its legal significance.

This Court's decision in *Rush Prudential* simply did not address the core question that has divided the courts of appeals with respect to AWP statutes. Citing *Royal Drug*, *Rush Prudential* reiterates the settled rule that the saving clause applies to the "business of insurance" rather than the "business of insurers." Slip op. 8. Thus, "when insurers are regulated *with respect to their insurance practices*, the state law survives ERISA." *Id.* (emphasis added). But beyond this reiteration of settled law, the Court in *Rush Prudential* had no cause to address the critical question of what constitutes an "insurance practice." Cf. *id.* ("this is not the place to plot the exact perimeter of the saving clause"). This Court's decision, including its holding that HMOs are insurers for purposes of the saving clause, did not speak to that issue. If these cases were remanded in light of *Rush Prudential*, the lower courts would accordingly continue to disagree over whether state regulation of contracts between insurers and third-parties, such as the provider networks at issue in these cases, constitutes regulation of "insurance practices," and the circuit conflict would continue unabated. Cf. *id.* at 7 (recognizing that the vague wording of ERISA's preemption and saving clauses regularly require the Court to address specific conflicts arising under the statute).

Nor should this Court defer review of the question presented in the outside hope that the circuits will now line up uniformly on one side of the split or the other. The uncertain status of AWP statutes, which exist in half the states, is simply too important an issue to remain unresolved. As the Solicitor General explained in response to this Court's invitation

to state the views of the United States, certiorari is warranted with respect to the question presented because "[t]he issue that has caused the conflict in the circuits, as well as the accompanying difficulty the courts have had in analyzing AWP laws, is important." S.G. Br. 19. Because "[m]anaged-care entities subject to the strictures of these laws deliver a substantial portion of health services nationwide," "[i]t is important that the permissible scope and limits of state authority in this area be defined." *Id.*

The petition for certiorari in No. 00-1295 demonstrated (at 26) that the AWP statutes of at least nine different states have been challenged in fourteen different lawsuits, with more than half invalidated. Indeed, it is no exaggeration to say that the legal controversy over the status of AWP statutes has been greater than with respect to "any other state law regulating managed care organizations." Larry J. Pittman, *"Any Willing Provider" Laws And ERISA's Savings Clause: A New Solution For An Old Problem*, 64 TENN. L. REV. 409, 428 (1997).

The number of opportunities for the lower courts to revisit the entrenched circuit conflict will moreover be limited because the question presented arises in the context of many state laws that have already been invalidated and thus go unenforced. Specific judgments of federal courts now prohibit insurance officials in Alabama, Arkansas, Georgia, Louisiana, and Texas from applying their states' AWP statutes (00-1295 Pet. 26 & n.12); the decisions of the Fifth and Eighth Circuits that AWP statutes are preempted furthermore presumptively prohibit enforcement of such laws in Minnesota, Mississippi, North Dakota, and South Dakota (see *id.* 2). Whatever might be said regarding the relevance of this Court's decision in *Rush Prudential* to the question presented, there certainly is no plausible argument that it renders AWP statutes *a fortiori* lawful.

As a consequence, AWP laws in many states will remain unenforced, such that they will not be subject to challenge; the Fifth and Eighth Circuits, in turn, are unlikely to be pre-

sented with further opportunities to revisit their prior decisions. Health benefit plans will therefore be left to suffer through the intolerably inconsistent state regulation of provider networks.

In sum, these cases present an ideal opportunity for the Court to resolve this uncertain state of affairs and to further define the parameters of the insurance savings clause so as to avoid needless and time consuming litigation in the future. They accordingly contrast in every important respect with *United States Healthcare Systems of Pennsylvania* v. *Pennsylvania Hospital Insurance Co.*, which the Court similarly held pending its decision in *Rush Prudential* but subsequently denied certiorari (No. 01-200, order of June 24, 2002).

Petitioners finally respectfully suggest that the petitions for certiorari be consolidated for briefing and argument. Petitioners have agreed among themselves that oral argument will be conducted by one counsel. Consolidating the cases simply ensures that both sets of petitioners receive equal status in briefing rather than relegating one to the role of an *amicus*.

CONCLUSION

For the foregoing reasons as well as those set forth in the petition and reply, certiorari should be granted and the cases consolidated.

Respectfully submitted,

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Counsel in No. 00-1295

June 24, 2002

No. 00-1471

IN THE

Supreme Court of the United States

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., *et al.*,
Petitioners,

v.

JANIE MILLER, COMMISSIONER OF THE KENTUCKY DEPARTMENT OF INSURANCE,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

JOINT APPENDIX

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Attorneys for Respondent

Petition for a Writ of Certiorari filed March 22, 2001
Certiorari Granted June 28, 2002

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APPENDIX A

General Docket
US Court of Appeals for the Sixth Circuit

Court of Appeals Docket #: 98-6308 Filed: 10/1/98
Nsuit: 3950 Constitutional - State Statute
KY Assoc Health Plan, et al v. Nichols
Appeal from: Eastern District of Kentucky at Frankfort

* * * *

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC. Plaintiff - Appellant	Barbara Reid Hartung FTS 587-3695 502-589-4200 [COR ret] Greenebaum, Doll & McDonald 101 S. Fifth Street Suite 3300 National City Tower Louisville, KY 40202-3197 Robert N. Eccles FTS 383-5414 202-383-5363 [COR LD NTC ret] Karen M. Wahle FTS 383-5414 202-383-5366 [COR ret] O'Melveny & Myers 555 13th Street, N.W. Suite 500

	Washington, DC 20004-1109
ADVANTAGE CARE INC Plaintiff - Appellant	Barbara Reid Hartung (See above) [COR ret] Robert N. Eccles (See above) [COR LD NTC ret] Karen M. Wahle (See above) [COR ret]
AETNA HEALTH PLANS OF OHIO, INC. Plaintiff - Appellant	Barbara Reid Hartung (See above) [COR ret] Robert N. Eccles (See above) [COR LD NTC ret] Karen M. Wahle (See above) [COR ret]
CHOICECARE HEALTH PLANS, INC. Plaintiff - Appellant	Barbara Reid Hartung (See above) [COR ret] Robert N. Eccles (See above) [COR LD NTC ret] Karen M. Wahle (See above)

[COR ret]

FHP OF OHIO INC.
Plaintiff - Appellant

Barbara Reid Hartung
(See above)
[COR ret]

Robert N. Eccles
(See above)
[COR LD NTC ret]
Karen M. Wahle
(See above)
[COR ret]

HMPK INC
Plaintiff - Appellant

Barbara Reid Hartung
(See above)
[COR ret]

Robert N. Eccles
(See above)
[COR LD NTC ret]
Karen M. Wahle
(See above)
[COR ret]

HPLAN INC
Plaintiff - Appellant

Barbara Reid Hartung
(See above)
[COR ret]

Robert N. Eccles
(See above)
[COR LD NTC ret]
Karen M. Wahle
(See above)
[COR ret]

HUMANA HEALTH PLAN INC.

Barbara Reid Hartung

Plaintiff - Appellant

(See above)
[COR ret]

Robert N. Eccles
(See above)
[COR LD NTC ret]
Karen M. Wahle
(See above)
[COR ret]

v.

GEORGE NICHOLS, III, in his official capacity as Commissioner of the Kentucky Department of Insurance
Defendant - Appellee

Anna R. Gwinn
FTS 564-1456
502-564-6032
[COR ret]
Elizabeth A. Johnson
502-564-6032
[COR LD NTC ret]
Kentucky Department of Insurance

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC.; ADVANTAGE CARE INC; AETNA HEALTH PLANS OF OHIO, INC.; CHOICECARE HEALTH PLANS, INC.; FHP OF OHIO INC; HMPK INC; HPLAN INC; HUMANA HEALTH PLAN INC.
Plaintiffs - Appellants

v.

GEORGE NICHOLS, III, in his official capacity as Commissioner of the Kentucky Department of Insurance
Defendant - Appellee

10/1/98 Civil Case Docketed. Notice filed by Appellants Health Maintenance, Advantage Care Inc, Aetna Health Plans, Choicecare Health, FHP of Ohio Inc, HMPK Inc, HPLAN Inc, Humana Health Plan. Transcript needed: y (ac)

10/5/98 Joint MOTION filed to consolidate for briefing and submission cases 98-5941/6308 . Motion filed by Shaun T. Orme for Appellee George Nichols, Karen M. Wahle for Appellants Humana Health Plan, HPLAN Inc, HMPK Inc, FHP of Ohio Inc, Choicecare Health, Aetna Health Plans, Advantage Care Inc, Health Maintenance. [98-6308] (ac)

* * * *

10/22/98 ORDER filed denying motion to consolidate 98-5941 with 98-6308 for briefing filed by Shaun T. Orme, Karen M. Wahle. [98-6308] (ac)

* * * *

11/9/98 Copy of District Court Order filed staying proceedings pending resolution by 6th Circuit. (ac)

* * * *

9/20/99 CAUSE ARGUED on 9/20/99 by Robert N. Eccles for Appellant Humana Health Plan, Appellant HPLAN Inc, Appellant HMPK Inc, Appellant FHP of Ohio Inc, Appellant Choicecare Health, Appellant Aetna Health Plans, Appellant Advantage Care Inc, Appellant KY Assoc Health Plan, Shaun T. Orme for Appellee George Nichols before Judges Kennedy, Norris, Holschuh. [98-6308] (me)

9/7/00 OPINION filed: The judgment of the district court is AFFIRMED in part and the case is REMANDED in part in

accordance with the opinion of this court, decision for publication pursuant to local rule 206. [98-6308] Cornelia G. Kennedy, Alan E. Norris, Circuit Judges, John D. Holschuh, Authoring Judge. (Judge Holschuh delivered the opinion of the court, in which Judge Norris joined. Judge Kennedy delivered a separate dissenting opinion with respect to Part III of the majority opinion) (ac)

9/7/00 JUDGMENT: AFFIRMED in part and REMANDED in part. (ac)

9/21/00 PETITION for en banc rehearing filed by Karen M. Wahle for Appellants Humana Health Plan, HPLAN Inc, HMPK Inc, FHP of Ohio Inc, Choicecare Health, Aetna Health Plans, Advantage Care Inc, KY Assoc Health Plan. Certificate of service date 9/20/00. [98-6308] (blh)

10/11/00 LETTER SENT by blh to Shaun T. Orme for Appellee George Nichols notifying that party is directed to respond to a petition for en banc rehearing [2225106-1] filed by Karen M. Wahle. Response due by 10/25/00. [98-6308] (blh)

10/25/00 RESPONSE to a petition for en banc rehearing [2225106-1] filed by Karen M. Wahle. Response filed by Elizabeth A. Johnson for Appellee George Nichols. Certificate of service date 10/24/00. [98-6308] (blh)

11/20/00 ORDER filed denying petition for en banc rehearing [2225106-1] filed by Karen M. Wahle [98-6308]. Cornelia G. Kennedy, Alan E. Norris, Circuit Judges; John D. Holschuh, District Judge. (blh)

11/29/00 MANDATE ISSUED with no cost taxed [98-6308] (ac)

* * * *

3/27/01 U.S. Supreme Court notice filed regarding petition for writ of certiorari filed by Appellant KY Assoc Health Plan. Filed in the Supreme Court on 03-22-01 , Supreme Ct. case number: 00-1471 . [98-6308] (swh)

7/8/02 U.S. Supreme Court letter filed granting petition for writ of certiorari [2329643-1] filed by KY Assoc Health Plan [98-6308]. Filed in the Supreme Court on 06-28-02 . (swh)

APPENDIX B

U.S. District Court

Eastern District of Kentucky (Frankfort)

CIVIL DOCKET FOR CASE #: 97-CV-24

Health Mntnc Orgnztn, et al v. Nichols

Filed: 04/04/97
Assigned to: Judge Joseph M. Hood
Demand: $0,000
Nature of Suit: 950
Lead Docket: None
Jurisdiction: Federal Question
Dkt# in other court: None
Cause: 28:1331 Federal Question: Other Civil Rights

HEALTH MAINTENANCE ORGANIZATION ASSOCIATION OF KENTUCKY, INC. plaintiff	John Armstrong West FAX 859-655-4239 [COR LD NTC] Greenebaum, Doll & McDonald P.O. Box 2673 50 E. Rivercenter Boulevard Suite 1800 Covington, KY 1012-2673 859-655-4200 Barbara Reid Hartung FAX 502-587-3695 [COR LD NTC] Greenebaum, Doll

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plaintiff
[term 02/22/01]

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Robert N. Eccles
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202-383-5300

AETNA HEALTH PLANS, of Ohio, Inc.
plaintiff

John Armstrong West
(See above)
[COR LD NTC]

Barbara Reid Hartung
(See above)

[COR LD NTC]

Robert N. Eccles
(See above)
[COR LD NTC]
Karen M. Wahle
(See above)
[COR LD NTC]

CHOICECARE HEALTH PLANS, INC.
plaintiff

John Armstrong West
(See above)
[COR LD NTC]

Barbara Reid Hartung
(See above)
[COR LD NTC]

Robert N. Eccles
(See above)
[COR LD NTC]
Karen M. Wahle
(See above)
[COR LD NTC]

FHP OF OHIO, INC.
plaintiff

John Armstrong West
(See above)
[COR LD NTC]

Barbara Reid Hartung
(See above)
[COR LD NTC]

Robert N. Eccles
(See above)
[COR LD NTC]

Karen M. Wahle
(See above)
[COR LD NTC]

HMPK, INC.
plaintiff

John Armstrong West
(See above)
[COR LD NTC]

Barbara Reid Hartung
(See above)
[COR LD NTC]

Robert N. Eccles
(See above)
[COR LD NTC]
Karen M. Wahle
(See above)
[COR LD NTC]

HPLAN, INC.
plaintiff

John Armstrong West
(See above)
[COR LD NTC]

Barbara Reid Hartung
(See above)
[COR LD NTC]

Robert N. Eccles
(See above)
[COR LD NTC]
Karen M. Wahle
(See above)
[COR LD NTC]

HUMANA HEALTH PLAN, INC.
plaintiff

John Armstrong West
(See above)

[COR LD NTC]

Barbara Reid Hartung
(See above)
[COR LD NTC]

Robert N. Eccles
(See above)
[COR LD NTC]
Karen M. Wahle
(See above)
[COR LD NTC]

v.

GEORGE NICHOLS, III, in his Official capacity as Commissioner of the Kentucky Department of Insurance
defendant

Anna R. Gwinn
[COR LD NTC]
Shaun T. Orme
[term 12/12/00]
[COR LD NTC]
Julie M. McPeak
[COR LD NTC]
Elizabeth A. Johnson
[COR LD NTC]
Kentucky Department of Insurance
P.O. Box 517
215 W. Main Street
Frankfort, KY 40601
502-564-6032

DOCKET PROCEEDINGS

DATE # DOCKET ENTRY

4/4/97 1 COMPLAINT (2 summons(es) issued) with copy, Fee Paid $150.00, Receipt No. 065225 (cbd)

* * * *

4/15/97 4 RETURN OF SERVICE executed upon defendant George Nichols III on 4/7/97 by certified mail (cbd)

4/15/97 5 RETURN OF SERVICE executed upon A. B. Chandler III, Kentucky Attorney General on 4/7/97 by certified mail (cbd) [Edit date 06/04/97]

4/24/97 6 NOTICE OF INTENTION NOT TO INTERVENE by Attorney General KY (cbd)

4/25/97 7 ANSWER by defendant George Nichols III to [1-1] (cbd)

* * * *

8/19/97 24 MOTION by plaintiff Advantage Care, Inc., plaintiff Aetna Health Plans, plaintiff ChoiceCare Hlth Pln, plaintiff FHP of Ohio, Inc., plaintiff HMPK, Inc., plaintiff HPlan, Inc., plaintiff Humana Hlth Plan Inc, plaintiff KY Dept. of Ins., plaintiff Health Mntnc Orgnztn for partial summary judgment (cbd)

* * * *

9/16/97 31 MOTION by plaintiff Advantage Care, Inc. for preliminary injunction (cbd) [Entry date 09/17/97]

* * * *

9/19/97 34 RESPONSE by defendant George Nichols III to Motion for Preliminary Injunction [31-1] (cbd) [Entry date 09/22/97]

9/22/97 35 GENERAL MINUTES: before Joseph M. Hood Date(s) 9/22/97 Court Reporter K. Marshall IT IS ORDERED that all admin. enforcement actions now before the Commisioner and any other proceedings that may brought before the Comm. are STAYED pending Court's ruling on parties cross motions for summary judgment (cc: all counsel) (cbd)

10/15/97 36 MOTION by defendant George Nichols III for partial summary judgment (cbd)

* * * *

11/24/97 40 RESPONSE by plaintiff to motion for partial summary judgment [36-1] (cbd)

* * * *

12/15/97 42 REPLY by defendant George Nichols III to response to motion for partial summary judgment [36-1] (cbd)

12/15/97 -- SUBMITTED re motion for partial summary judgment [36-1] (cbd)

* * * *

8/6/98 43 MEMORANDUM OPINION AND ORDER: by Judge Joseph M. Hood; 1) pltfs' motion for partial summary judgment [24-1] is DENIED, 2) dft's mtn for partial sum jgm is GRANTED [36-1] (cc: counsel) (cbd)

* * * *

9/3/98 45 UNOPPOSED MOTION by plaintiff for partial final judgment under Rule 54(b), or, alternatively certification under 28 U.S.C. 1292(b) (cbd)

* * * *

9/3/98 -- SUBMITTED re motion for partial final judgment under Rule 54(b) [45-1], re motion certification under 28 U.S.C. 1292(b) [45-2] (cbd)

* * * *

9/18/98 48 ORDER by Judge Joseph M. Hood; IT IS ORDERED pltfs' motion for partial final judgment under Rule 54(b) [45-1] is GRANTED 2) ct's order dated 8/6/98 [Record No. 43] is FINAL and APPEALABLE and THERE IS NO JUST CAUSE FOR DELAY (cc: all counsel) (cbd) [Edit date 09/23/98]

9/22/98 49 MEMORANDUM OPINION: by Judge Joseph M. Hood; this ct believes that entry of a partial final jgm under Rule 54(b) as to Count I of the pltfs' cmp is warranted. A sep. order will this date issue (cc: all counsel) (cbd) [Entry date 09/23/98]

9/22/98 50 JUDGMENT: by Judge Joseph M. Hood; ORDERED, ADJUDGED, and DECREED that Count I of pltfs' Cmp is dismissed (cc: all counsel) (cbd) [Entry date 09/23/98]

9/25/98 51 NOTICE OF APPEAL by plaintiff Humana Hlth Plan Inc, plaintiff HPlan, Inc., plaintiff HMPK, Inc., plaintiff FHP of Ohio, Inc., plaintiff ChoiceCare Hlth Pln, plaintiff Aetna Health Plans, plaintiff Advantage Care, Inc., plaintiff Health Mntnc Orgnztn from Dist. Court decision entered 9/22/98 [50-1], [49-1], 9/18/98 [48-1], 8/11/98 [44-1] (cc: all counsel) (cbd)

* * * *

11/6/98 55 ORDER by Judge Joseph M. Hood; this action is stayed pending resolution of this issue by 6CCA (cc: all counsel) (cbd)

* * * *

12/1/00 58 MANDATE from 6CCA: ORD jgm of district ct is AFFIRMED in part & the case is REMANDED in part in accordance w/ the opinion of this ct [Appeal [51-1] (cbd) [Entry date 12/04/00]

* * *

2/22/01 63 GENERAL MINUTES: before Joseph M. Hood Date(s) 2/12/01 Court Reporter Ann Banta: ORD oral mtn of Advantage Care, Inc. for voluntary dismissal is GRANTED. Oral mtn by pltf for stay of action pending ruling on Writ of Certiorari is GRANTED. If Writ is denied, dft shall have 30 days from ruling to file his mtn for sum jgm & pltf shall have 15 days thereafter to respond (cc: all counsel) [EOD Date: 2/22/01] (cbd)

* * * *

7/10/02 -- REMARK: Pet for writ of cert granted 6/28/02. (sam)

END OF DOCKET: 3:97cv24

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APPENDIX C

Humana
Health Care Plans

HCT02AA4

KENTUCKY PHYSICIAN'S PLAN

Offered by Humana Health Plan, Inc.

Louisville, Kentucky 40201

Group Plan Sponsor:

HEALTHCARE RECOVERIES, INC.

Group Plan Number: 41308 Plan 006 Option 620

CERTIFICATE OF COVERAGE

We, Humana Health Plan, Inc., will directly provide or pay for the services described under the provisions of the Group Plan to you and your dependents, if any. If we provide the service directly, we arrange or contract with physicians, hospitals, and other providers of medical care and employ administrative personnel to directly provide, organize, and arrange for such service.

The physicians, hospitals, and providers of medical care are not our agents or employees, nor are we their agents or employees.

HUMANA HEALTH PLAN, INC.

President

HP 1/86

HCT03AX0

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DEFINITIONS

ELIGIBILITY AND EFFECTIVE DATES

TERMINATION PROVISION

COORDINATION OF BENEFITS PROVISIONS APPLICABLE TO ALL SERVICES

RIGHT OF REIMBURSEMENT

PROVISIONS APPLICABLE TO MEDICARE ELIGIBLES

PROVISIONS FOR REIMBURSEMENT OR PAYMENT OF SERVICES

GRIEVANCE PROCEDURE

HEALTH SERVICES AGREEMENT

CO-PAYMENT SCHEDULE

HDF01BX0

DEFINITIONS

Here are some terms used in your certificate. Other terms may be defined in the sections which follow.

ACCIDENT means a non-occupational injury which is:

1. caused by an event which is sudden and unforeseen; and
2. exact as to time and place of occurrence.

ACTIVE SERVICE means that you are performing all of your regular duties on a full-time basis for your employer on a regularly scheduled work day. You will be considered to be in active service on a non-scheduled work day only if you are in active service on the last regularly scheduled work day.

ADMISSION means entry into a facility as a registered inpatient according to the rules and regulations of that facility. An admission ends when the insured person is discharged, or released, from the facility and is no longer registered as an inpatient.

AFFILIATE means a company effectively controlled by the group or associated with the group under common ownership or control. The group must notify us and receive our approval as to which affiliates will be covered under the Group Plan.

AMBULANCE means a professionally operated vehicle equipped for the transportation of a sick or injured person to or from the nearest medical facility qualified to treat the person's sickness or injury. Use of the ambulance must be medically necessary and/or ordered by a physician and must be the most reasonable method of transportation.

AMBULATORY SURGICAL CENTER means an institution which meets all of the following requirements.

1. It must be operated by physicians and a medical staff which includes registered nurses.
2. It must have permanent facilities and equipment for the primary purpose of performing surgical procedures.
3. It must provide continuous physicians' services on an outpatient basis.
4. It must admit and discharge patients from the facility within the same work day.
5. It must be licensed in accordance with the laws of the jurisdiction where it is located. It must be run as an ambulatory surgical center as defined by those laws.
6. It must not be used for the primary purpose of terminating pregnancies, or as an office or clinic for the private practice of any physician or dentist.

HDF02AX0

CALENDAR YEAR means the period of time which begins on any January 1st and ends on the following December 31st. When a person first becomes covered under the Group Plan, the first calendar year begins for him or her on the effective date of his or her coverage and ends on the December 31st coinciding with or next following his or her effective date.

CERTIFICATE means this document, which describes the services provided and to whom and how services are provided or paid.

CHILD means your natural born child, legally adopted child or a stepchild. The term also includes any child for whom you are the legal guardian; a child who is dependent upon you for health care coverage pursuant to a valid court order; or any child who lives with you in a normal parent-child relationship if the child qualifies for the dependent exemption on your current income tax forms under the Internal Revenue Code and the Federal Tax Regulations. We have the right to request proof of the child's dependency status.

CO-PAYMENT AMOUNT OR CO-PAYMENT PERCENTAGE means that dollar amount or percentage of charges for covered services which must be paid to the provider of the services by or on behalf of the member receiving them.

DAY means a 24-hour period starting at 12:01 a.m. at the group's address.

HDF03BA0

DEPENDENT means:

1. your lawful spouse; and
2. an unmarried child from birth to age 19. The term also includes a child under the age of 25, if that child is enrolled in an educational institution as a full-time student and is actively attending class on a regular basis. Semester breaks do not jeopardize a child's dependent status. However, if a child is not enrolled and actively attending an institution as a full-time student for the semester following the break, that child will no longer be considered a dependent under the Group Plan and coverage will terminate.

DURABLE MEDICAL EQUIPMENT means equipment, recognized as such by Medicare Part B, that meets all of the following criteria.

1. It can stand repeated use.
2. It is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience.
3. It is usually not useful to a person in the absence of sickness or injury.
4. It is appropriate for home use.
5. It is related to the patient's physical disorder.
6. It is for temporary use only.
7. It is certified in writing by a physician as being medically necessary.

ELECTIVE PROCEDURE means a medical procedure which: is not considered to be an emergency; and may be delayed by the member to a later point in time.

EMPLOYEE means a person who is in active service for the group or an affiliate on a full-time basis. The employee must be paid by the group or affiliate for work done at the group's or affiliate's usual place of business or some other location which is usual for the employee's particular duties, other than the employee's home.

EXPERIMENTAL OR INVESTIGATIONAL means a drug, biological product, device, medical treatment or procedure that meets any one of the following criteria, as determined by us:

1. **Reliable Evidence** shows the drug, biological product, device, medical treatment, or procedure when applied to the circumstances of a particular patient is the subject of ongoing phase I, II, or III clinical trials, or
2. **Reliable Evidence** shows the drug, biological product, device, medical treatment, or procedure when applied to the circumstances of a particular patient is under study with a written protocol to determine maximum tolerated dose, toxicity, safety, efficacy, or efficacy in comparison to conventional alternatives, or
3. **Reliable Evidence** shows the drug, biological product, device, medical treatment, or procedure is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the U.S. Food and Drug Administration or the Department of Health and Human Services.

RELIABLE EVIDENCE shall mean only published reports and articles in the authoritative medical and scientific literature; the PDQ database of the National Cancer Institute; the written protocol or protocols used by the treating facility or the protocols of another facility studying substantially the same drug, biological product, device, medical treatment, or procedure; the written informed consent used by the treating facility or another facility studying substantially the same drug, biological product, device, medical treatment, or procedure; or regulations and other official actions and publications issued by the U.S. Food and Drug Administration or the Department of Health and Human Services.

FULL-TIME, for an employee, means a work week of at least 30 hours.

GROUP means the Group Plan Sponsor.

HDF04DX1

GROUP PLAN means the document describing the full plan of services we provide or pay for as contracted for by the group.

HOSPITAL means an institution which meets all of the following requirements.

1. It must provide, for a fee, medical care and treatment of sick or injured patients on an inpatient basis.
2. It must provide or operate, either on its premises or in facilities available to the hospital on a pre-arranged basis, medical, diagnostic and surgical facilities.
3. Care and treatment must be given by and supervised by physicians. Nursing services must be provided on a 24 hour basis and must be given by or supervised by registered nurses.
4. It must be licensed by the laws of the jurisdiction where it is located. It must be run as a hospital as defined by those laws.
5. It must not be primarily a:

   a. convalescent, rest or nursing home; or
   b. a facility providing custodial care or educational services.

The term also includes licensed or accredited treatment facilities which are properly accredited to provide psychiatric, diagnostic and therapeutic services for the treatment of patients who have mental illnesses. In addition, if services specifically for the treatment of a physical disabil'- are provided in a licensed hospital, provision of those services will not be denied solely because such hospital is primarily of a rehabilitative nature and lacks surgical facilities. However, the hospital must be accredited by one of the following:

1. the Joint Commission on Accreditation of Healthcare Organizations;
2. the American Osteopathic Hospital Association; or
3. the Commission on the Accreditation of Rehabilitative Facilities.

HOSPITAL CONFINEMENT or **HOSPITAL CONFINED** means that a member is a registered inpatient in a hospital as the result of a physician's recommendation.

INJURY means non-occupational bodily loss or harm.

HDF05AX1

INTENSIVE CARE UNIT means a special unit of a hospital which:

1. treats patients with serious sicknesses or injuries;
2. can provide special life-saving methods and equipment;
3. admits patients without regard to prognosis; and
4. provides constant observation of patients by a specially trained nursing staff.

MEDICAID means a state program of medical care for needy persons, as established under Title 19 of the Social Security Act of 1965, as amended.

MEDICAL COMPLICATIONS OF PREGNANCY means conditions needing hospital confinement where the diagnosis is different from pregnancy, but the diagnosed condition may be caused or affected by it. These conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion, puerperal infection and disease of the vascular system. Also included are serious medical and surgical conditions relating to pregnancy, such as hemopoietic nervous or endocrine systems, hyperemesis gravidarum, toxemia and eclampsia of pregnancy. It also includes non-elective caesarean section, miscarriage and ectopic pregnancy which is terminated or the spontaneous termination of a pregnancy which occurs during a period of gestation in which a viable birth is not possible.

This term does not include conditions such as false labor, occasional spotting, bed rest prescribed by a physician, morning sickness or any similar problems caused by a difficult pregnancy which cannot be classified as distinct from the pregnancy.

MEDICAL EMERGENCY means a physical condition for which services are required to provide an immediate diagnosis and treatment of a condition which occurs suddenly and unexpectedly and could become a threat to life or limb if medical services were not rendered immediately.

MEDICARE means a program of medical insurance for the aged and disabled, as established under Title 18 of the Social Security Act of 1965, as amended.

MEDICALLY NECESSARY SERVICES means services and supplies ordered by a physician and customarily recognized in the physician's profession as appropriate in the care and treatment of the patient's diagnosed sickness or injury.

In order to be considered medically necessary, the services or supplies must be:

1. consistent with the symptom or diagnosis and treatment of the member's injury or sickness;
2. appropriate with regard to standards of good medical practice;
3. not solely for the convenience of a member, physician, hospital or ambulatory care facility; and
4. the most appropriate supply or level of service which can be safely provided to the member. When applied to the care of an inpatient, it further means that the member's medical symptoms or conditions require that the services cannot be safely provided to the member on an outpatient basis.

MEMBER means you or any dependent while covered under the Group Plan.

NON-PARTICIPATING HOSPITAL means a hospital which has not been designated as a participating hospital by us to provide services to members.

NON-PARTICIPATING PHYSICIAN means a physician who has not been designated as a participating physician by us to provide services to members.

NON-PARTICIPATING PROVIDER means a non-participating hospital, a non-participating physician or another provider who has not been designated as a participating provider by us to provide services to members.

NURSE means a registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.).

ORAL SURGERY means procedures to correct diseases, injuries and defects of the jaw and mouth structures. These procedures include but are not limited to the following:

1. Surgical removal of full bony impactions.
2. Mandibular (staple) implant.
3. Maxillary or mandibular frenectomy.
4. Alveolectomy and alveoplasty.
5. Orthognathic surgery.
6. Periodontal surgery, including gingivectomies.

OUTPATIENT means that a member is not hospital confined.

OUTPATIENT SURGERY means surgery that is performed in a physician's office, ambulatory surgical center, free-standing medical clinic or the outpatient department of a hospital.

OPEN ENROLLMENT PERIOD means that period of time in each Group Plan year when, by agreement between the group and us, eligible persons can enroll in the Group Plan or terminate their coverage.

PARTICIPATING HOSPITAL means a hospital which has signed an agreement with us or has been designated by us to provide services to members.

PARTICIPATING PHYSICIAN means a physician who has signed an agreement with us or has been designated by us to provide services to member.

PARTICIPATING PROVIDER means a participating hospital, a participating physician or another provider who has signed an agreement with us or has been designated by us to provide services to members. A complete list of participating providers will be given to you.

PERIOD OF CONFINEMENT means one period of confinement, except successive periods of confinement are considered one period unless the second period of confinement is due to injury or sickness entirely unrelated to the prior period of confinement. If the second period of confinement is due to an injury or sickness related to the condition which caused the first confinement, the confinements will be considered separate if the member is free of hospital confinement for at least 7 consecutive days.

PERIODONTICS means the branch of dentistry concerned with the study, prevention and treatment of diseases of the tissues and bones supporting the teeth.

PHYSICIAN means a licensed medical practitioner who is practicing within the scope of his or her license and whose services are required to be covered under the Group Plan by the laws of the jurisdiction where the treatment is given.

PSYCHIATRIC DISORDER means neurosis, psychoneurosis, psychopathy or psychosis.

PSYCHIATRIC TREATMENT PROGRAM means those services offered by licensed mental and nervous programs, licensed drug abuse rehabilitation programs, and alcoholism rehabilitation programs. These programs must be accredited by the Joint Commission on the Accreditation of Healthcare Organizations or in compliance with equivalent standards or be approved by the state where the program is run.

REASONABLE CHARGES mean charges that do not exceed negotiated schedules of payments developed by us which are accepted by Participating Providers within a geographic area specified by us as payment in full. Services rendered inside this specified geographic area by Non-Participating Providers will be reimbursed according to these Participating Provider schedules, unless otherwise agreed to by the Group and us. In the event that an insured receives services outside this specified geographic area, services will be covered according to reimbursement schedules developed by independent organizations and fee schedule companies for the area in which the services are rendered.

ROOM AND BOARD means all services provided by a hospital, including room and meals and all general services and activities needed for the care of registered bed patients.

ROUTINE NURSERY CARE means the charges made by a hospital for the use of the nursery. It includes normal services and supplies given to well newborn children following birth. Physician visits are not considered routine nursery care. Treatment of an injury, sickness, birth abnormality, congenital defect following birth and care resulting from prematurity is not considered routine nursery care.

SERVICE OR SERVICES means any services or supplies we cover under the Group Plan.

SICKNESS means any non-occupational disease or illness. The term also includes: (a) pregnancy; (b) any medical complications of pregnancy; and (c) a covered newborn's congenital defects or birth abnormalities, including premature birth for which more than routine nursery care is required.

SOUND NATURAL TEETH means teeth that are free of active or chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by multiple dental procedures.

SUBSCRIBER means you, while you are covered under the Group Plan.

SURGICAL PROCEDURE means any of the following procedures (excluding oral surgical procedures):

1. incision, excision or electrocauterization of any organ or body part;
2. reconstruction of any organ or body part or the suture repair of lacerations;
3. reduction of a fracture or dislocation by manipulation;
4. use of endoscopic procedure to explore for or to remove a stone or other object from the larynx, bronchus, trachea, esophagus, stomach, intestine, urinary bladder or ureter;
5. puncture for aspiration;
6. injection for contract media testing; or
7. laser surgery.

TOTAL DISABILITY or **TOTALLY DISABLED** means your continuing inability, as the result of injury or sickness, to perform the material and substantial duties of any occupation for which you are suited by reason of education, training or experience. The term also means a dependent's inability to engage in the normal activities of a person of like age. If a dependent is employed, the term means the dependent's inability to perform his or her job.

WEEKEND NON-EMERGENCY HOSPITAL ADMISSION means an admission to a hospital on a Friday or a Saturday at the convenience of the member or his or her physician when there is no cause for an emergency admission and the member receives no surgery or therapeutic treatment until the following Monday or later.

YOU, YOUR OR YOURS means the person who is eligible for coverage under the Group Plan as a subscriber. It does not mean any person who is covered as a dependent under the Group Plan.

WE, US or OUR means the Humana Health Plan, Inc.

HPHCR032

ELIGIBILITY AND EFFECTIVE DATES

EFFECTIVE DATE FOR SUBSCRIBERS

A person who is eligible for coverage may elect to be covered by the Group Plan only by signing an enrollment form approved and accepted by us. The effective date of coverage depends upon the date on which the person enrolls.

Subject to the PROVISO and your making any required subscription fee contributions, your coverage will start as described in the paragraphs which follow.

1. If you are eligible for coverage on the effective date of the Group Plan, your coverage will start:

   a. on the effective date of the Group Plan if you enrolled for coverage on or before that date.
   b. on the date you enroll if you enroll later than, but within 31 days after, the effective date of the Group Plan.

   If you become eligible after the effective date of the Group Plan, and you enroll on or before the date you become eligible, your coverage will start the date you become eligible.

2. If you become eligible after the effective date of the Group Plan and you enroll within 31 days after the date you become eligible, your coverage will start on the date you enroll.

3. If you must make subscription fee contributions for your coverage and you enroll more than 31 days after the date you became eligible or you apply to reinstate coverage that has lapsed, you must give us evidence of your health status at no cost to us. If we approve this evidence, your coverage will start on the day we specify.

PROVISO. If you are not actively at work on the date your coverage would become effective, it will not become effective until you return to active service. If you are not actively at work when your coverage is being changed, increased, or services are being added while you are covered under the Group Plan, the change, increase, or new services will not become effective for you until you return to active service. This proviso will not apply to retirees, if any, covered under the Group Plan.

HPHCR034

ELIGIBILITY FOR YOUR DEPENDENTS

You become eligible for coverage for your dependents on the latest of the following dates:

1. the date you become eligible for coverage; or
2. the date you acquire your first dependent; or
3. the date on which provisions covering dependents are made a part of the Group Plan.

If a dependent is eligible for coverage as a subscriber, you may not enroll him or her as both a subscriber and a dependent. In addition, no one may be considered as a dependent of more than one subscriber.

EFFECTIVE DATE FOR YOUR DEPENDENTS

You may elect to cover your dependents by the Group Plan only by signing an enrollment form approved and accepted by us. The effective date of coverage for each dependent depends on the date on which you enroll for coverage for that dependent.

Subject to the PROVISO, the coverage for your dependents will start as shown below; however, it will not start before you become a subscriber and make any required subscription fee contributions.

1. The coverage for each dependent becomes effective on the date you enroll for it, if you enroll for coverage for your dependent(s) on or before the date you: (a) become eligible for dependent coverage; or (b) first acquire the dependent.

2. If you enroll for coverage for your dependent(s) within 31 days after you either become eligible for dependent coverage or first acquire the dependent, the coverage for each dependent becomes effective on the later of: (a) the date you become eligible; or (b) the date of enrollment.

3. If you must make subscription fee contributions for dependent coverage, the coverage for each dependent becomes effective on the date we accept the dependent's evidence of health status and agree in writing to cover the dependent if you enroll for dependents coverage more than 31 days after: (a) you become eligible for dependent coverage; or (b) you first acquire the dependent. If evidence must be given, it must be provided at your expense.

PROVISO. If a dependent, other than a newborn, is hospital confined on the date his or her Health Services coverage would become effective, it will not become effective until the day after he or she is discharged from the hospital. This also applies to change, increase or addition of Health Services while the dependent is covered under the Group Plan.

NEWBORN CHILDREN

If you have or acquire a newborn child as a dependent, the child is automatically covered under the Health Services Agreement from the moment of birth if you enroll the newborn for dependent coverage no later than 31 days after the date of the child's birth and make any required subscription fee contributions.

SPECIAL ENROLLMENT

If you or one of your eligible dependent(s) waived coverage under this Group Plan during the initial eligibility period and enrolled under your spouse's health plan, you or your dependent(s) may enroll under this Group Plan without medical underwriting if one of the following events occurs:

1. Your spouse's employer terminates coverage;or
2. Your spouse terminates employment; or
3. Your spouse has a change in hours or a change in position (for example switching from full-time to part-time); or
4. Your spouse dies.

When coverage is elected under this provision, enrollment must be completed within 31 days following the date coverage terminates under your spouse's plan; and, you may enroll only those eligible persons who were covered under your spouse's plan.

SPECIAL PROVISIONS FOR THE REPLACEMENT OF COVERAGE

If the Group Plan replaces the group's prior plan of group medical coverage and you are totally disabled or have a pre-existing condition, you may have limited coverage under the Group Plan. To be eligible for this limited coverage:

1. you must have been covered by the prior plan of group medical coverage on the day before the Group Plan becomes effective for the group; and
2. you must be in an eligible class under the Group Plan on the date it becomes effective for the group.

Limited coverage will be provided as follows:

TOTAL DISABILITY - We will provide limited coverage for totally disabled persons covered under the prior plan's extension of benefits as follows:

1. the Group Plan will provide benefits only for those covered medical services not directly related to the totally disabling condition; and
2. the Group Policy will not cover medical services directly related to the totally disabling condition. These services may be covered under the prior plan's extension of benefits provision, if any.

Our limited coverage of the totally disabled person will continue until the earliest of the following dates:

1. the date the person's total disability ends. If the total disability ends before the prior plan's extension of benefits is exhausted, the person will be eligible for the full coverage of the Group Plan, provided the person:
   a. returns to active service, if he or she is a subscriber; or
   b. is not hospital confined, if he or she is a dependent.

   No waiting period or pre-existing condition limitation will apply.
2. the date the person's coverage under the Group Plan terminates in accordance with the termination provisions of the Group Plan; or

SPECIAL PROVISIONS FOR THE REPLACEMENT OF COVERAGE (CONTINUED)

3. the date the prior plan's extension of benefits for the disabling condition is exhausted. If the person is still totally disabled at that time, the coverage of the Group Plan terminates. If the totally disabled person had dependent coverage under the Group Plan, coverage for his or her dependents also terminates.

If your coverage under the Group Plan terminates because the prior plan's extension of benefits is exhausted, you may convert your coverage, and that of your eligible dependents, in accordance with the conversion privilege of the Group Plan. The conversion privilege does not apply to a totally disabled dependent who exhausts the prior plan's extension of benefits.

When a former subscriber, whose coverage under the Group Plan was terminated because the prior plan's extension of benefits was exhausted, is no longer totally disabled, he or she must satisfy a new waiting period in order to become eligible for coverage again. In addition, the pre-existing condition limitation of the Group Plan will be applied.

When a former dependent, whose coverage under the Group Plan was terminated because the prior plan's extension of benefits was exhausted, is no longer totally disabled, he or she may become eligible for coverage again only if you have dependent coverage at that time. The pre-existing condition limitation will be applied.

PRE-EXISTING CONDITIONS - We will compare the pre-existing condition limitations of the Group Plan and the prior plan. The shortest limitation will become the adjusted limitation period and will be used to determine when coverage will be provided under the Group Plan, as follows.

1. If you satisfied the adjusted limitation period while covered under the prior plan, full coverage for the pre-existing condition will be provided under the Group Plan.

2. If you have not satisfied the adjusted limitation period, we will credit the period of time you were covered under the prior plan. You must then satisfy the remainder of the adjusted limitation period while covered under the Group Plan. Once the adjusted limitation period is fully satisfied, full coverage for the pre-existing condition will be provided under the Group Plan.

SPECIAL PROVISIONS FOR THE REPLACEMENT OF COVERAGE (continued)

WAITING PERIOD CREDITS - If you had not satisfied the waiting period of the prior plan on the day that plan ended, any periods of time that were satisfied will be applied to the appropriate waiting period of the Group Plan, if any.

DEDUCTIBLE CREDIT - If you become covered by the Group Plan, we will reduce the co-payment amounts of the Group Plan for the first calendar year by the amount of same or similar covered medical services received under the prior plan which were applied to that plan's current deductible before the prior plan ended. This credit will not apply if the Group Plan is replacing a health maintenance organization plan.

CO-PAYMENT LIMITS - Any amounts applied to the prior plan's co-payment limit or stop-loss limit WILL NOT be credited toward the satisfaction of any co-payment limits of the Group Plan.

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TERMINATION PROVISIONS

TERMINATION OF YOUR COVERAGE

Your coverage will terminate on the earliest of the following dates:

1. the date you cease to be in a class of eligible persons or cease to qualify as a subscriber;
2. the last day for which you make any required subscription fee contribution for your coverage;
3. the last day for which the group makes any required subscription fee contribution for coverage on your behalf;
4. the date the Group Plan is terminated;
5. the date your Lifetime Maximum Covered Services Amount is reached; or
6. 31 days from the date you receive written notice that your coverage is being terminated for cause, as set forth on the next page.

TERMINATION OF YOUR DEPENDENT COVERAGE

A dependent's coverage will terminate on the earliest of the following dates:

1. the date your coverage terminates;
2. the date you cease to be in a class of persons eligible for dependent coverage;
3. the last day for which you make any required subscription fee contribution for dependent coverage;
4. the last day for which the group makes any required subscription fee contribution for dependents coverage on your behalf;
5. the date dependent coverage or the Group Plan is terminated;
6. the date a dependent reaches his or her Lifetime Maximum Covered Services Amount;
7. the date a dependent no longer qualifies as a dependent; or
8. 31 days from the date the dependent receives written notice that his or her coverage is being terminated for cause, as set forth on the next page.

HIT02AE0

TERMINATION FOR CAUSE

We will terminate a member's coverage for cause under the following circumstances:

1. If, after reasonable efforts, a satisfactory physician-patient or provider-patient relationship cannot be established or maintained with a member.
2. If a member fails to pay or arrange to pay his or her co-payments.
3. If a member allows an unauthorized person to use his or her identification card or uses the identification card of another subscriber. Under these circumstances, the person who receives the services provided by use of the identification card will be responsible for paying us the usual, customary and reasonable charges for those services.
4. If a member is disruptive for reasons unrelated to his or her use of medical services and the behavior prevents treatment to the member or other members of the Plan.
5. If a member or group perpetrates fraud and/or misrepresentation on claims or identification cards in order to obtain services or a higher level of benefits. This includes, but is not limited to, the fabrication and/or alteration of a claim or identification card.

A member who is being terminated for cause has 10 days from the date his or her coverage would otherwise terminate to initiate the Grievance Procedure. The member's coverage will continue until the Grievance Procedure is complete.

HANDICAPPED CHILDREN

If a dependent child who has reached the maximum age shown in the definition of dependent meets all of the requirements shown below, we extend dependents coverage under the Health Services Agreement for that child for as long as you remain covered for dependent coverage.

1. The child must be incapable of self-sustaining employment because of mental or physical handicap.
2. The child must rely on you for financial support.

You must give us proof of the child's handicap within 31 days of the date his or her Health Services coverage would otherwise end. We may request further proof of the child's continued incapacity from time to time during the 2-year period after the date the handicapped child reached the maximum age. After this 2-year period, we may only request further proof of the child's incapacity annually.

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RETIREMENT

If your active service ends because you retire, coverage will be continued until the date the group stops paying subscription fees for your coverage or otherwise terminates your coverage.

Any continuation of coverage must not be done on a selective basis.

HIT04CB0

WHEN COVERAGE TERMINATES UNDER THE HEALTH SERVICES AGREEMENT

If a member's coverage under the Health Services Agreement terminates:

1. it may be extended under the Extension of Coverage Under the Health Services Agreement provision, if the member is totally disabled when the Group Plan terminates;
2. it may be converted to a plan of medical coverage as described in the Health Services Agreement Conversion provision; or
3. it may be continued under the Optional Continuation of Health Services Coverage provision, if your health services coverage ends and is not replaced within 31 days.

A complete description of these provisions and when a member qualifies under these provisions follows.

EXTENSION OF COVERAGE UNDER THE HEALTH SERVICES AGREEMENT

We continue to provide or pay limited covered Health Services if the Group Plan terminates while a member is continuously totally disabled due to an illness or injury that commenced while this contract is in effect. The member must provide written notice to us within 31 days from the date the Group Plan terminates of his or her intention to receive extended benefits. Services are provided or paid only for the same injury or sickness which caused the member to be continuously totally disabled. Services for the disabling condition are provided or paid without subscription fee payment only while the member remains continuously totally disabled, until the earliest of:

1. the date the member is no longer continuously totally disabled; or
2. the date the member becomes covered by any medical coverage plan carried or sponsored by the employer;
3. the date the member's Lifetime Maximum Covered Services Amount, if any, is reached; or
4. the last day of the 3-month period following the date the Group Plan terminated.

No Health Services are extended to a child born as a result of a member's pregnancy which existed when the Group Plan terminated.

This provision does not apply to covered retired members.

HIT06ABO

HEALTH SERVICES AGREEMENT CONVERSION

WHO MAY CONVERT

If a member has been covered under the Health Services Agreement of the Group Plan and any prior plan replaced by the Group Plan for at least a total of 3 full calendar months, he or she may obtain a plan of medical benefits (called the conversion plan). A conversion plan may be obtained by:

1. you, if your Health Services coverage under the Group Plan terminates. You may also include in the conversion plan any dependents who were covered by the Group Plan on the date your coverage ends.
2. your covered spouse whose Health Services coverage under the Group Plan ends because of termination of the marriage or because of your death.
3. your covered child whose Health Services coverage under the Group Plan ends because he or she no longer qualifies as a dependent or because of your death.
4. your covered dependents when your Health Services coverage under the Group Plan ends and you cannot convert because you are eligible for Medicare.

No conversion plan is available if:

1. the member is eligible for Medicare;
2. issuance of the conversion plan would result in the member being overinsured.

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A person will be considered to be overinsured if: his or her coverage under the Group Plan is replaced by similar group coverage within 31 days of the date coverage ends; or the benefits of the conversion plan, when combined with similar benefits, result in an excess of coverage. Similar benefits include:

1. those for which the person is covered by a hospital, medical, or surgical or medical expense insurance policy, by a hospital or medical service subscriber contract, or by a medical practice or other prepayment plan;
2. those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or
3. those available for the person by or through any state, provincial or federal law, other than Medicaid.

HOW TO CONVERT

We will give all of the necessary information about conversion to a member who is entitled to convert so that application may be made. Evidence of health status will not be required to obtain a conversion plan. A member entitled to convert must apply in writing and pay the first subscription fees on the conversion plan within 31 days after he or she is given proper notice of the right to conversion. Proper notice is written notice that is mailed or delivered to the member's last address as given by you to the Group Plan. In the event a member has this conversion right but does not receive proper notice of it, he or she can still apply. To do so the member must apply in writing and pay the first subscription fees on the conversion plan within 91 days after his or her eligibility for coverage under the Health Services Agreement ends. A member who does not so apply will not be entitled to a conversion plan.

THE CONVERSION PLAN

The conversion plan will be one we offer or arrange to offer at the time the first subscription fees are received.

The conversion plan is issued to you if you are entitled to convert. It will cover you and those dependents for whom you must convert. If you are not entitled to convert and your covered dependents are, the conversion plan is issued to the spouse and will cover all such dependents. If the conversion plan is for an individual dependent, it will be issued to that dependent.

The conversion plan takes effect on the day after the person's Health Services coverage under the Group Plan ends. The subscription fees of the conversion plan on its effective date are based on: (1) the class of risk to which the person entitled to convert belongs: (2) that person's age; and (3) the benefits chosen.

The conversion plan may not exclude any pre-existing condition not excluded by the Group Plan. During the first 12 months that the conversion plan is in effect, the amount payable by it may be reduced. The reduction would be equal to the services provided or paid by the Extension of Coverage Under the Health Services Agreement provisions of the Group Plan so that the total amount payable by the conversion plan and the services provided or paid by the Group Plan do not exceed the services that would be provided or paid by the Group Plan if the person's coverage had not ceased. After 12 months, the amount payable by the conversion plan will be reduced by any services still provided or payable by the Extension of Coverage Under the Health Services Agreement provisions of the Group Plan.

OPTIONAL CONTINUATION OF HEALTH SERVICES COVERAGE

If you are no longer eligible for coverage under the Health Services Agreement of the Group Plan, you may choose to continue these services for up to 9 months after the date your Health Services coverage terminates. You must give us written notice of your choice to continue coverage within 31 days after you are given proper notice of your right to continuation.

Proper notice is written notice that is mailed or delivered to your last address as given by you to the Group Plan.

In the event you have this right of continuation but you do not receive proper notice of it, you can still make the election. To do so you must make proper payment of subscription fees within 91 days after your eligibility for coverage under the Health Services Agreement ends.

You are responsible for sending us the subscription fee payments if you choose to continue coverage. If you fail to make proper payment of subscription fees to us, we are relieved of all liability for any coverage that was continued.

The option to continue coverage is not available if: (1) the Group Plan terminates or coverage for your entire class terminates and is not replaced by another group policy within 31 days after your coverage terminates; (2) you are eligible for similar group benefits, either on an insured or uninsured basis; (3) you were not covered by the Group Plan and the prior plan replaced by the Group Plan for at least 3 months prior to the date your coverage terminates; (4) you are eligible for Medicare; or (5) you are eligible for continuation under the Optional Continuation of Health coverage provision.

If you were covered under the Health Services Agreement for dependents coverage when your Health Services coverage terminated, you may choose to continue coverage for any dependent who was covered by the Group Plan. You cannot add dependents to your coverage during a period of continuation. The same terms with regard to the availability of continued coverage described above will apply to dependents.

Continued coverage terminates on the earliest of the following dates: (1) the last day of the 9 month period following the date you were no longer eligible for coverage; (2) the date you became covered for similar group benefits, either on an insured or uninsured basis; (3) the date you fail to make any required subscription fee contribution; (4) the date you reach your Lifetime Maximum Covered Services Amount; or (5) the date the Group Plan terminates and is not replaced by similar group benefits within 31 days.

Continued coverage for dependents terminates on the earlier of: the date your continued coverage terminates; or the date the dependent no longer qualifies as a dependent.

If continued coverage terminates and is not replaced by similar group coverage, you or your dependents may choose to convert to a conversion plan. To convert, you or your dependent must satisfy the terms of the Group Plan which apply to health services conversion.

CONTINUATION OF COVERAGE FOR DEPENDENTS

If your dependents are no longer eligible for coverage under the Health Services Agreement of the Group Plan because of your death or dissolution of marriage, or, with respect to a dependent child alone, ineligibility which results because he or she reaches the limiting age of the Group Plan, the ineligible dependent(s) may choose to continue coverage for up to 9 months after the date coverage terminates. This continuation is subject to the same terms, conditions and termination provisions as described for you under the Optional Continuation of Health Services Coverage above.

HIT1GAA0

OPTIONAL CONTINUATION OF HEALTH COVERAGE

The following provisions apply only to employer groups who elect to comply with provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA).

If a covered person is no longer eligible for the coverage provided by the Group Plan because of one of the qualifying events described below, that person may choose to continue that coverage. He or she will be responsible for payment of the appropriate subscription fees for continued coverage, including any portion that the employer may have paid on his or her behalf.

The group will be responsible for sending us the subscription fee payments for those individuals who choose to continue their coverage. If the group fails to make proper payment of subscription fees to us, we are relieved of all liability for any coverage that was continued and the liability will rest with the group.

There are two categories of persons eligible for continued coverage. Persons eligible to continue are called "beneficiaries." Notification requirements and the period of time for which coverage may be continued differs for each category.

CATEGORY 1 BENEFICIARIES are:

1. Surviving spouses of covered employees and their dependent children;
2. Divorced or legally separated spouses and their dependent children;
3. Spouses of Medicare-eligible employees and their dependent children; and
4. Dependent children who become ineligible under the terms of the Group Plan.

Coverage for any of these individuals may be continued for up to 36 months following the date of the qualifying event.

Surviving spouses and spouses of Medicare-eligible employees who wish to continue coverage must notify the employer within 30 days of the qualifying event resulting in loss of coverage. Divorced or legally separated spouses and dependent children who become ineligible for coverage must notify the employer within 60 days of the later of (a) the date of the qualifying event or (b) the date the qualified beneficiary would lose coverage on account of the qualifying event. Within 14 days of receipt of the notice of a qualifying event, the employer will provide a form on which to indicate election of continued coverage. The form must be returned to the employer within 60 days of receipt. Coverage will continue during this 60-day period if the appropriate subscription fee is paid within 45 days of the date of election of continued coverage.

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OPTIONAL CONTINUATION OF HEALTH COVERAGE (CONTINUED)

CATEGORY 2 BENEFICIARIES are

1. Employees whose employment is terminated for reasons other than gross misconduct; and
2. Employees whose working hours have been reduced so that they are no longer eligible for coverage under the Group Plan.

Coverage for these individuals may be continued for up to 18 months following the date of termination or reduction of hours.

Your employer will give you a form to elect continuation of coverage for you and your covered dependents, if any, at the time of your termination or reduction in hours, or within 30 days of the event. The form must be returned to your employer within 60 days of receipt. Coverage will continue during this 60-day period if you pay the appropriate subscription fees within 45 days of the date you elect to continue the coverage.

If an employee is terminated for gross misconduct, he or she may continue coverage under the continuation coverage required by state law, if any.

TERMINATION OF CONTINUED COVERAGE

Continued coverage will terminate immediately for individuals in either category at the earliest of the following dates:

1. the date the employer ceases to provide any group health plan to employees;
2. the date the beneficiary fails to make timely subscription fee payments;
3. the date the beneficiary becomes covered under this or any other group health plan or becomes entitled to benefits under Medicare; or
4. the date a spouse remarries and becomes covered by another group health plan.

If continued health coverage terminates and is not replaced by similar group coverage, you and your dependents may choose to convert to a conversion plan. To convert, the terms of the Group Plan which apply to health services conversion must be satisfied.

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COORDINATION OF BENEFITS PROVISIONS APPLICABLE TO ALL SERVICES

DEFINITIONS

Here are some terms used in this provision.

ALLOWABLE EXPENSE means any necessary and reasonable item of expense at least a part of which is covered by any one of the plans that covers the person for whom claim is made. When the benefits from a plan are in the form of services rather than cash payments as may be the case with this plan, the reasonable cash value of each service is both an allowable expense and, for purposes of this provision, a benefit provided or payable.

COVERAGE DETERMINATION PERIOD means a calendar year or that part of a calendar year in which the person has been covered by this plan.

As used in this Coordination of Benefits provision only, **PLAN** means the coverage of medical or dental expenses or services by:

1. any group insurance plan, on an insured or uninsured basis;
2. group service plan contracts, group or individual practice or other pre-payment plans; or
3. labor-management trusteed plans, union welfare plans, employers organization plans or employee benefit organization plans.

The term does not include coverage under individual or franchise policies or contracts. Each plan or part of a plan which has the right to coordinate benefits is considered to be a separate plan.

WHAT A COORDINATION OF BENEFITS PROVISION DOES

If a person is covered by this plan and by any of the other plans described above, a coordination of benefits provision will be used when the amount of benefits provided or payable by this plan and the amount of benefits payable by any of the other plans for the same services would exceed the total amount of allowable expenses in a claim determination period.

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All benefits provided or payable under this plan are subject to coordination. A coordination of benefits provision determines:

1. the order in which all plans provide or pay their benefits; and
2. when, depending on the order of benefit determination, a plan may reduce or recover its benefit so that not more than 100% of the total amount of allowable expenses is provided or paid jointly by all plans.

ORDER OF BENEFIT DETERMINATION

In order to administer this provision, it is first necessary to determine the order in which all of the plans provide coverage. This order is shown below.

1. A plan which does not contain a coordination of benefits provision is considered to provide coverage before a plan which does contain a coordination of benefits provision.

2. A plan which covers a person on a basis other than coverage for dependents is considered to provide coverage before a plan which covers a person as a dependent.

3. A plan which covers a person as the dependent of a person whose birthday anniversary occurs earlier in the calendar year is considered to provide coverage before a plan which covers the person as the dependent of a person whose birthday anniversary occurs later in the calendar year. If either one of the plans does not have this "birthday rule" provision, then the plan without this provision is considered to determine its benefits before the plan which does contain this provision. In the case of divorced or legally separated parents, the order of benefit determination is as shown below.

   a. If there is a court decree which establishes financial responsibility for a dependent child's health care expenses, the plan of the parent with that responsibility is considered to provide coverage before the plan of the parent without the responsibility.

b. If there is no such decree and the parent with custody of the child has not remarried, the plan which covers the child as a dependent of the parent with custody is considered to provide coverage before the plan of the parent without custody.

c. If the parent with custody of the child has remarried:

   1) the plan which covers the child as a dependent of the parent with custody provides coverage first;

   2) the plan which covers the child as a dependent of the step-parent provides coverage second; and

   3) the plan which covers the child as a dependent of the parent without custody provides coverage third.

If the above rules fail to establish the order of benefit determination, the plan which has covered the person for the longest time is considered to provide coverage first. However, a person may be covered as an active employee by one plan and as a retired or laid-off person by another plan. In this case, if both plans contain a provision regarding retired or laid- off employees, the plan which covers the person as an active employee is considered to provide coverage before the plan which covers the person as a retired or laid-off employee.

HOW BENEFITS ARE COORDINATED

If, based on the order of benefit determination, the benefits of this plan are provided or paid first, the coverage provided or paid by the other plans is ignored when we provide or pay services. If our plan's coverage should be provided or paid after that of any other plan, we add up the coverage provided or paid by each of the plans in the order in which it should be provided or paid and compare the total benefits to the total amount of allowable expenses. If the services we have provided or paid plus the coverage provided or paid under the other plans results in coverage which exceeds total allowable expenses, we have the right to reduce our benefit payment or recover the reasonable value of the services to the extent of the excess over total allowable expenses from: any person to whom such coverage was provided or benefits were paid, any insurance company, health care plan or other organization. This right of recovery shall be exercisable at our sole discretion.

The member shall, upon our request, execute such instruments or papers as may be required to secure our rights. When coordination of benefits reduced the total amount otherwise covered in a coverage determination period for a person covered by our plan, each service that would have been covered in the absence of coordination is reduced in proportion. The reduced amounts are charged against any applicable benefit limits of our plan. In no event will our provision of services be more than it would have been in the absence of other plans.

We reserve the right to release to or obtain from any insurance company or other organization or person any information which, in our opinion, we need for the purpose of coordination of benefits.

When services should have been provided or paid by our plan based on the terms of this provision and payments have been made by any other plan, we have the right to pay to any organization making these payments an amount we consider to be warranted. Amounts paid in this manner are considered to be services provided or paid by our plan. After we make such payments, we have no further liability.

When we have made an overpayment, we have the right to recover that payment to the extent of the excess. We may recover the overpayment from the person to whom it was made or from any insurance company or organization as described in these Coordination of Benefits provisions.

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PROVISIONS FOR SUBROGATION AND RIGHT OF REIMBURSEMENT

RIGHTS OF RECOVERY

Our intention is to preserve and assert our rights to recover for sums paid or benefits provided where circumstances warrant the assertion of our rights, to the fullest extent allowed by the applicable laws of the jurisdiction involved. Each provision below shall be considered severable, and if any provision is determined to be unenforceable or void, the remaining provisions shall remain unaffected.

SUBROGATION

This provision applies when another party (person or organization) is, or may be, considered responsible for causing injury or for payment of benefits due to a member's injury or sickness for which benefits under the Group Plan have been provided or paid. To the extent of such benefits, we are subrogated to all rights and claims for recovery the member has against any party (including a health care carrier) responsible for the injury for payment to the member on account of the injury.

RIGHT OF REIMBURSEMENT

If payment (by settlement, judgment or any other manner) is made, or may be made, in the future by, or on behalf of, a responsible party to the member, expenses arising from the member's injury or sickness are not covered by us.

However, if we receive a claim for which benefits would be payable in the absence of a responsible party as described above, we will pay those benefits subject to the following conditions:

1. We will automatically have a lien to the extent of benefits advanced upon any recovery, by settlement, judgement or otherwise that you receive from the responsible party, or any person or organization making payment on behalf of the responsible party, including first party, underinsured and uninsured motorist coverage. The lien will be in the amount of benefits provided or paid by us for the treatment of the condition for which the third party is responsible.

2. You agree to notify us, in writing, within 60 days of your claim against the responsible party and to take such action, furnish such information, cooperate generally, and execute any documents as we may require to facilitate enforcement of our rights.

Exclusively at our option and choice, and without any waiver of any other rights of the Group Plan, in the event of prejudice, non-cooperation or breach of this Group Plan, we may withhold, deduct or retract payments to or on behalf of the member.

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DUPLICATION OF BENEFITS/OTHER INSURANCE

This provision is intended to prevent overpayment or duplication of benefits under this Group Plan when other health care coverage provides the same benefits. It applies when a person is covered by us and has, or is entitled to, benefits as a result of their injuries from any other coverage including, but not limited to, first party uninsured or underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers compensation settlement or awards, other group coverage (including student plans), direct recoveries from liable parties, premises medical pay or any other insurer providing coverage that would apply to pay your medical expenses, except other group health carriers in which case coverage will be determined under Coordination of Benefits.

Where there is such coverage, we will not duplicate other coverage available to the member and shall be considered secondary, except where specifically prohibited. Where double coverage exists, we shall have the right to be repaid from whomever has received the overpayment to the extent of the duplicate coverage.

This provision applies whether or not the member has made a claim under other applicable coverage. When applicable, the member is required to provide us with authorization to obtain information about the other coverage available, and to cooperate in the recovery of overpayments from the other coverage, including executing any assignment of rights necessary to obtain payment directly from the other coverage available.

COOPERATION REQUIRED

The member shall cooperate by providing information and executing any documents to preserve our right and shall have the affirmative obligation of notifying us that claims are being made against responsible parties to recover for injuries for which we have paid. If the member enters into litigation or settlement negotiations regarding the obligations of the other party, the member must not prejudice, in any way, our rights to recover an amount equal to any benefits we have provided or paid for the injury or sickness. Failure of the member to provide us such notice or cooperation, or any action by the member resulting in prejudice to our rights will be a material breach of this Group Plan and will result in the member being personally responsible to make repayment. In such an event, we may deduct from any pending or subsequent claim made under the Group Plan any amounts the member owes us until such time as cooperation is provided and the prejudice ceases.

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PROVISIONS APPLICABLE TO MEDICARE ELIGIBLES

DEFINITIONS

Here are some definitions of words used in this provision.

MEDICARE PART A means the Social Security program which provides hospital insurance benefits.

MEDICARE PART B means the Social Security program which provides medical insurance benefits.

For the purposes of determining benefits provided for a member who is eligible to enroll for Medicare Part B, but does not, we assume the amount provided under Medicare Part B to be the amount the member would have received if he or she had enrolled for it.

A member is considered to be eligible for Medicare on the earliest date coverage under Medicare could become effective for him or her.

INTEGRATION WITH MEDICARE

The way in which services under the Group Plan are provided or paid for a member who is eligible for Medicare is as follows. If services are provided directly by the Group Plan, we then have the right to recover the full amount of all Medicare benefits the member is entitled to receive, whether or not the member is actually enrolled for them. The member should authorize payment of Medicare benefits directly to us for services rendered. If the member does not authorize direct payment, he or she is responsible to us for the reasonable value of the services rendered. The member is also responsible to us for the reasonable value of all Group Plan services reimbursable by Medicare if the member is not enrolled for all benefits he or she is entitled to receive.

If the member receives covered services from a non-participating provider, the way in which covered services are paid for a member who is age 65 or older and eligible for Medicare is shown below.

1. If services are received which are covered by both the Group Plan and Medicare Part A, we pay for those services which exceed the amount payable by Medicare Part A.

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2. If services are received which are covered by both the Group Plan and Medicare Part B, we reduce our covered services by the amount of benefits provided for those covered services by Medicare Part B.
3. Any co-payment amount of the Group Plan will apply only to covered services received for prescription drugs and nurses.

For a member who is under age 65 and eligible for Medicare, the services provided by the Group Plan will be reduced so that no more than 100% of all of the services received are provided jointly by the Group Plan and Medicare.

When an employer employs 100 or more persons, the services of the Group Plan will be provided or paid first for a member who is under 65 and eligible for Medicare. The benefits of Medicare will be paid second.

TEFRA OPTIONS

When an employer is subject to the Tax Equity And Fiscal Responsibility Act of 1982 (TEFRA), TEFRA allows actively working covered employees age 65 or older and their covered spouses who are eligible for Medicare to choose one of the following options if the employee is: age 65 or older; and eligible for Medicare.

OPTION 1 - The services of the Group Plan will be provided or paid first and the benefits of Medicare will be payable second.

OPTION 2 - Medicare benefits only. You and your dependents, if any, will not be covered by the Group Plan.

The employer must provide you, and each covered spouse, with the choice to elect one of these options at least one month before you, or the covered spouse, becomes age 65. All new employees and newly covered spouses age 65 and older must be offered these options. If Option 1 is chosen, its issue is subject to the same requirements as for an employee or dependent who is under age 65.

Under the TEFRA regulations, there are two categories of persons eligible for Medicare. The calculation and payment of benefits by the Group Plan differs for each category.

CATEGORY 1 Medicare Eligibles are:

1. actively working covered employees age 65 or older who choose Option 1;
2. the age 65 or older covered spouses; and
3. age 65 or older covered spouses of actively working covered employees who are under age 65.

CATEGORY 2 Medicare Eligibles are any other covered persons entitled to Medicare, whether or not they enrolled for it. This category includes, but is not limited to:

1. retired employees and their spouses; or
2. covered dependents of a covered employee, other than his or her spouse.

CALCULATION AND PROVISION OF SERVICES

For members in Category 1, services are provided or paid by the Group Plan without regard to any benefits paid by Medicare. Medicare will then determine its benefits.

For members in Category 2, if services are provided directly by the Group Plan, we then have the right to recover the full amount of all Medicare benefits the member is entitled to receive, whether or not the member is actually enrolled for them. The member should authorize payment of Medicare benefits directly to us for services rendered. If the member does not authorize direct payment, he or she is responsible to us for the reasonable value of the services rendered. The member is also responsible to us for the reasonable value of all Group Plan services reimbursable by Medicare if the member is not enrolled for all benefits he or she is entitled to receive.

If services are received by a member in Category 2 from a non-participating provider, Medicare benefits are paid before any services are paid by the Group Plan. The covered services of the Group Plan will then be reduced by the full amount of all Medicare benefits the member is entitled to receive, whether or not they are actually enrolled for them.

PROVISIONS FOR REIMBURSEMENT OR PAYMENT OF SERVICES

GROUP PLAN ON A DIRECT SERVICE BASIS

We provide or arrange for services to be received from participating providers on a direct service basis. If you receive services from a participating provider, we will pay the provider directly for all care you receive. You will not have to submit a claim for payment.

In the event you elect to use a non-participating provider or require medical emergency services from a non-participating provider or if we refer you to a non-participating provider, we will attempt to arrange for direct payment to that non-participating provider. If the non-participating provider refuses direct payment, you will be reimbursed for the cost of the services. You will not be reimbursed for more than the reasonable charges for the cost of the services.

The following provisions apply in the event you need to file a claim.

WE MUST BE NOTIFIED

Notice of a claim must be given to us. The notice must be in writing. Any claim will be based on the written notice. The notice must be received by us within 15 months after the start of the loss on which the claim is based. If notice is not given in time, the claim may be reduced or invalidated. If it can be shown that it was not reasonably possible to submit the notice within the 15 month period and that notice was given as soon as possible, the claim will not be reduced or invalidated.

The member must follow the procedures outlined in the Schedule of Medical Emergency Coverage at Non-Participating Providers in order to have care rendered by a non-participating provider covered as though it were provided by a participating provider. After we have been notified, the member will be advised as to how the cost of the care will be paid.

WE FURNISH CLAIMS FORMS

After we receive written notice of claim, we provide claim forms. This form should be furnished within 15 days after we receive written notice. If we fail to furnish this form within 15 days, the claimant can meet the time period shown below for submitting proof of loss by submitting written proof which explains the reasons for the claim. Written proof should establish facts about the claim such as occurrence, nature and extent of the loss involved.

WHEN TO FILE PROOF OF LOSS

Participating providers are responsible for submitting claims for covered expenses directly to us on the member's behalf. Health care providers who have entered into a reimbursement agreement with us have agreed not to bill you for an amount greater than the difference between the Reasonable charges and the benefit amount paid by us. You will need to complete and sign all necessary papers and authorize participating providers to release those medical records which may be necessary to complete the processing of your claim. Benefit payments for covered services received from a participating provider will be forwarded directly to the provider.

Written proof of loss must be given to us within 15 months after the date of the loss for which claim is made. If proof of loss is not submitted and received by us within the required time period, the claim may be reduced or invalidated. If it can be shown that it was not reasonably possible to submit the proof within the time period and that the proof was submitted as soon as possible, the claim will not be reduced or invalidated.

WE MAY EXTEND TIME LIMITS

If the time limit we allow for giving notice of claim or submitting proof of loss is less than the law permits in the state where the claimant lives, we extend our time limits to agree with the minimum period specified by that state's laws. The law must exist at the time the Group Plan is issued.

WHEN WE PAY

We will pay for covered services provided after the member has made any required co-payments. No covered services are payable for charges which are discounted, waived or rebated by a provider of services simply because the member is covered. We have the right to recover from a provider of services or from a member any excess covered services paid for charges which were discounted, waived or rebated.

If a member dies while covered services remain unpaid, we may choose to pay up to $3,000, or the amount required by state law, to:

1. any person or persons related to the member by blood or marriage who appears to be entitled to the payments; or
2. the executors or administrators of the member's estate.

We will be discharged of liability to the extent of any such payments made in good faith.

If any person to whom payment is to be made is a minor or, in our opinion, not able to give a valid receipt for any payment due him or her, such payment will be made to his or her legal guardian. However, if no request for payment has been made by the legal guardian, we may, at our option, make payment to the person or institution appearing to have assumed his or her custody and support.

OUR RIGHT TO REQUIRE MEDICAL EXAMS

We have the right to require that a medical exam be performed on any claimant for whom a claim is pending as often as we may reasonably require. If we require a medical exam, it will be performed at our expense.

TIME OF PAYMENT OF CLAIMS

Claims for covered services will be paid when we receive proper written proof of loss.

LEGAL ACTIONS AND LIMITATIONS

No action at law or in equity may be brought to recover under the Group Plan until at least 60 days after written proof of loss has been filed with us. If action is to be taken after the 60 day period, it must be taken within the applicable statute of limitations in the state where the claimant lives.

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GRIEVANCE PROCEDURE

There are situations when members are dissatisfied with Plan services. Such complaints will be handled in a timely manner.

The person responsible for the maintenance of records and for the supervision of the grievance process is the Executive Director/ Designee. A specific set of records will be maintained to document grievances filed. Records will include reason for grievance, date filed, consequent actions and final disposition. They will be centrally maintained by the Grievance Manager.

The Plan will encourage members to resolve individual problems without initiation of a formal grievance procedure by contacting the Customer (Member) Services Representative for verbal resolution. Refer to your I.D. card for the Customer (Member) Service phone number. Grievances must be submitted within 30 days of occurrence, unless good cause can be shown. The Customer (Member) Services Representative must respond to the complaint within three working days of the submission.

In the event the grievance has not been settled at the informal level and the member is still dissatisfied, he or she will be advised to appeal the decision in writing to the Plan's Grievance Manager. In the case of a medical or quality care grievance, the investigation will include referral to a Physician Advisor for consultation, but the process will remain the same. The Plan's Grievance Manager will provide written acknowledgment of receipt of the grievance to the member within five working days; the grievance will be investigated and a response sent to the member no later than 30 working days following the initial filing of appeal with the Plan Grievance Manager. The member of any interested party may submit written data which will remain part of the file.

If the member is not satisfied with the response, he or she may appeal directly to the Plan's Grievance Committee. The member will be advised in writing of his or her right to appeal the decision. The Grievance Committee shall have written guidelines for investigating grievances and conducting informal hearings. As before, receipt of the grievance will be acknowledged within five working days by the Grievance Committee and resolution suggested within 30 working days. If the member remains dissatisfied with the decision of the Grievance Committee, he or she will be advised of the right to appeal to the Insurance Commissioner. The Plan will cooperate with the Commissioner and the member during the appeal.

HHS01EX1

HEALTH SERVICES AGREEMENT

SERVICES WE PROVIDE OR PAY

Each member is entitled to receive the covered services described below. All such covered services:

1. must be medically necessary as a result of sickness or injury unless specified otherwise;
2. must be received from or provided to a member under the orders, direction and approval of a physician;
3. are subject to the exclusions and limitations described elsewhere in this agreement;
4. are subject to any co-payment amounts or percentages stated in the Co-Payment Schedule; and
5. must not exceed reasonable charges for the services.

Co-payments and maximum amounts, if any, for each covered service are shown in the Copayment Schedule. We calculate co-payments by applying the dollar amount or percentage to net charges. Net charges are defined as gross billed charges less any discounts or fee negotiations that may have been arranged with participating providers. Gross charges means the amount the provider charges without giving consideration to any of the discounts which we have arranged to receive from the provider.

We will pay participating physicians for covered expenses in accordance with the fee schedules of reasonable charges established between the participating physicians and us. For services rendered by participating physicians, the dollar amount of the co-payment or co-payment percentage that is your responsibility is calculated based on the fee schedule of the participating physician rendering the services. For services rendered by non-participating physicians, the dollar amount of the deductible or benefit percentage is calculated based on a reimbursement schedule established by us and agreed to by your employer. When using a non-participating physician, you are also responsible for any charges that exceed this reimbursement schedule and any non-covered services.

Services are deemed to be received on the date a covered service is performed or furnished. A service that is provided or paid as a covered service under a particular section of the Group Plan will not be considered a covered service under any other section of the Group Plan unless specified otherwise. A service will not be covered if it is received after your coverage under the Group Plan is terminated unless it is required to be covered by state law.

THE CO-PAYMENT AMOUNT

If a member receives covered services, services are provided or paid after any co-payment amount has been paid. There is an individual co-payment amount and a family co-payment amount. After the family co-payment amount has been met, no further co-payment amount is required for the remaining members in that family for those services for the remainder of the period shown in the Co-Payment Schedule. The co-payment amount for each member and the family co-payment amount are shown for all services, or for a portion of services, in the Co-Payment Schedule. They must be satisfied during the period shown for them. If a member receives services in a non-participating hospital, the non-participating hospital co-payment amount must be satisfied first, then the calendar year co-payment amount.

If two or more members of the same family are injured in the same accident and receive covered services for those injuries, only one co-payment amount will be deducted from the total covered services resulting from the accident in the calendar year in which the accident occurs.

In addition, only one co-payment amount will be deducted from the total covered services received as a result of a multiple birth of two or more dependents. The covered services must be received in the same calendar year as the birth and result from:

1. premature birth;
2. an abnormal congenital condition; or
3. an injury or sickness occurring within 30 days after the birth.

CO-PAYMENT LIMIT

The co-payment limit is the amount of covered services, excluding amounts applied to the co-payment amount, that must be paid by each member in the period shown in the Co-Payment Schedule before we increase the co-payment percentage we provide or pay. After the co-payment limit has been satisfied, covered services for the member are provided or paid at the rate of 100% for the rest of the period shown for them in the Co-Payment Schedule.

There is also a family co-payment limit. After the family co-payment limit has been satisfied, covered services for members in that family are provided or paid at the rate of 100% for the rest of the period shown for them in the Co-Payment Schedule.

The co-payment limit for each individual and each family is shown in the Co-Payment Schedule. However, covered services provided or paid in connection with psychiatric disorders, alcoholism or drug abuse will be provided or paid as shown in the Co-Payment Schedule for them and will not apply towards the satisfaction of the individual or family co-payment limits.

LIFETIME MAXIMUM COVERED SERVICES AMOUNT

The total amount of covered services we pay on behalf of and/or provide to a member in his or her lifetime will not exceed the lifetime maximum covered services amount shown in the Co-Payment Schedule.

If a member uses any portion of his or her lifetime maximum covered services amount, we will furnish the used portion again on each January 1, up to a maximum of $1,000. The $1,000 will be applied to covered services received after the date of reinstatement. Once a lifetime maximum covered services amount has been reached, services will not be reinstated.

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PRE-AUTHORIZATION PROVISIONS

All coverage provided under the Group Plan must be for services and supplies that are medically necessary. In order to determine whether services and supplies meet guidelines for medical necessity, they must be authorized by us in advance.

The member is responsible for alerting his or her physician regarding the need for prior approval. The identification card will alert the physician that pre-authorization is required and will show the telephone number to call to obtain the appropriate authorization. If prior approval of services or supplies is not obtained, coverage may be reduced or not paid at all.

WHEN EMERGENCY HOSPITALIZATION IS REQUIRED

If a medical emergency requires that a member be admitted to a hospital, we must be advised by the hospital of the admission immediately. We will then review the medical necessity of the admission. If the member has been admitted to a non-participating hospital, and it has been determined that the member's condition has stabilized sufficiently to allow the member to be transferred safely to a participating hospital, we will request that the member and the member's physician approve the transfer. If the transfer is not approved, all services, supplies and any days of hospital confinement at the non-participating hospital beyond the date the member's medical emergency was stabilized are not covered.

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MEDICAL SERVICES

Covered Medical Services include the following if they are received by a member as the result of an injury or sickness which occurs while covered under the Group Plan. Services are subject to the applicable co-payment amount or percentage shown on the Co-Payment Schedule.

1. Daily room and board and other medically necessary services and supplies provided while a member is hospital confined.
2. Routine nursery care for a newborn child for up to a maximum of 10 days following birth.
3. Confinement in an intensive care, cardiac care or neonatal unit, provided in place of services covered in (1) above.
4. Services and supplies furnished by an ambulatory surgical center.
5. Medical care and treatment of an injury or sickness provided by a physician.
6. Surgical procedures performed on an inpatient or outpatient basis.
7. Obstetrical services received on an inpatient or outpatient basis, including medically necessary prenatal and post-natal care of the mother.
8. Physician's care of a newborn child while the child is hospital confined immediately following birth for up to 10 days.
9. Anesthesia administered by a physician or certified registered anesthetist attendant to a surgical procedure.
10. Radiation therapy received on an inpatient or outpatient basis.

MEDICAL SERVICES (CONTINUED)

11. Consultation charges requested by the attending physician during a hospital confinement. This benefit is limited to one consultation by any one consultant per specialty during a hospital confinement.

12. Surgical assistance provided by a physician, when medically necessary. The benefit for surgical assistance will be 20% of the reasonable charge for the chief surgeon.

13. Inhospital medical services furnished by the attending physician to a hospital confined member.

14. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.

15. Outpatient medical care and treatment.

16. Private duty nursing in a hospital or in the home, by a nurse.

17. Radium therapy, x-ray treatments and examinations (other than dental x-rays), microscopic tests or any lab tests or analyses made for diagnosis or treatment; including the following performed for breast cancer screening:

    a. One screening mammogram for women age 35 through 39;

    b. One mammogram every two years for women age 40 through 49; and

    c. One mammogram per year for women age 50 and over.

18. The following services and supplies:

    a. administration of whole blood and blood components;

    b. casts, splints, trusses, crutches and braces (excluding replacement braces or dental braces);

    c. initial placement of a medically necessary prosthesis and its supportive device. We will also cover the replacement of such prothesis if it is determined by the member's physician to be necessary because of growth or changes;

    d. oxygen or rental of equipment for administration of oxygen;

MEDICAL SERVICES (CONTINUED)

    e. the initial pair of eyeglasses or contacts needed due to cataract surgery or an accident that occurs while covered under the Group Plan if the eyeglasses or contacts were not needed prior to the accident; and

    f. the purchase or rental of medically necessary durable medical equipment. If the cost of renting the equipment is more than a member would pay to buy it, only the cost of the purchase is considered to be a covered service. In either case, total covered services for durable medical equipment shall not exceed its purchase price and purchase or rental will be at our option. We do not provide or pay for equipment or devices not specifically designed and intended for the care and treatment of an injury or sickness.

19. Services of a speech therapist or pathologist to restore speech loss or impairment resulting from trauma, stroke or a surgical procedure while covered under the Group Plan. Services for any and all therapy covered under the Group Plan will be subject to a combined limit of 20 visits per calendar year.

20. Services of a licensed audiologist to determine and measure hearing loss which occurred while covered under the Group Plan. Services for any and all therapy covered under the Group Plan will be subject to a combined limit of 20 visits per calendar year.

21. Services of a licensed physical therapist for purposes of training to aid restoration of normal physical functions lost due to trauma, stroke or a surgical procedure while covered under the Group Plan. Services for any and all therapy covered under the Group Plan will be subject to a combined limit of 20 visits per calendar year.

22. Professional ambulance services.

MEDICAL SERVICES (CONTINUED)

HOME HEALTH CARE SERVICES

HOME HEALTH CARE AGENCY means a home health care agency or a hospital which meets all of the following requirements.

1. It must primarily provide skilled nursing services and other therapeutic services under the supervision of physicians or registered nurses.
2. It must be run according to rules established by a group of professional medical people, including physicians and nurses.
3. It must maintain clinical records on all patients.
4. It must be licensed by the jurisdiction where it is located, if licensure is required. It must be run according to the laws of that jurisdiction which pertain to agencies providing home health care.

HOME HEALTH AIDE means a person who provides care of a medical or therapeutic nature. The home health aide must report to and be under the direct supervision of a home health care agency.

HOME HEALTH CARE PLAN means a plan of care and treatment of a member in his or her home. To qualify, the home health care plan must be established and approved by a physician. The physician must also certify that the member would otherwise require confinement in a hospital or skilled nursing facility if he or she did not have the care stated in the home health plan.

Services are payable for covered expenses incurred in connection with a home health plan. The home health care services must begin within 30 days after a member's discharge from a hospital or skilled nursing facility or may be provided in lieu of an admission. If confined, home health care must be for the same condition which caused the confinement or a related condition. If home health care services are to be provided instead of a hospital admission, the services must receive prior approval from us. All home health care services and supplies must be provided on a part-time or intermittent basis to an member in conjunction with a home health care plan.

Home health care services include:

1. nursing care by or under the supervision of an R.N. or L.V.N.;
2. physical, occupational, respiratory or speech therapy, medical social work, nutrition services and home health aide services;
3. medical appliances and equipment, laboratory services and special meals, if such services and supplies would have been covered by the Group Policy if the member had been in a hospital;
4. services of a home health aide including extension of therapy services, personal care, ambulation and exercise, household services essential to health care, assistance with medications that are ordinarily self-administered, reporting changes in the member's condition and needs and completing appropriate records.

MEDICAL SERVICES (CONTINUED)

The Co-Payment Schedule shows the amount or percentage payable and the maximum number of visits allowed by a representative of a home health care agency. A combination of three (3) visits in a 24 hour period for all types of care will be considered a covered expense. A visit by any registered or licensed professional representative of a home health care agency, other than a home health aide, will be one home health care visit. A visit by a home health aide of four hours or less will be counted as one visit.

EXTENSION OF HOME HEALTH CARE PLAN

Benefits for home health care may be extended beyond the initial number of visits. A request for an extension must be made by a physician who certifies, in writing, the medical necessity of the additional visits. When a request for an extension is granted, only a limited number of additional home health care visits will be authorized. When that extension is exhausted, an additional extension may be requested. However, the total number of initial visits and extended visits may not exceed 100 visits per calendar year. NO SERVICES WILL BE PAYABLE for extended home health care visits if we do not approve the extension.

MEDICAL SERVICES (CONTINUED)

PRE-ADMISSION TESTING SERVICES

There are no deductibles and co-payment requirements for pre-admission tests that meet all of the following requirements.

1. The admission to the hospital or the scheduled outpatient surgery is confirmed in writing by the attending physician before the testing occurs.
2. The tests must be performed within 7 days before admission to the hospital or the outpatient surgery.
3. The tests must be ordered by the attending physician.
4. The tests are performed in a facility accepted by the hospital in place of the same tests which would normally be done while hospital confined.
5. The tests are not duplicated in the hospital.
6. The member is subsequently admitted to the hospital or the outpatient surgery is performed, unless a hospital bed is unavailable or there is a change in the member's health condition which would preclude the procedure.

If these requirements are not met, the co-payment amount or percentage for Medical Services will apply to the pre-admission testing services.

PRE-ADMISSION TESTS means laboratory tests or x-ray examinations done on an outpatient basis in a hospital or other facility accepted by the hospital within seven days before a planned hospital confinement or outpatient surgery.

MEDICAL SERVICES (CONTINUED)

PSYCHIATRIC DISORDERS, ALCOHOLISM AND DRUG DEPENDENCY SERVICES

Services provided by a physician, or a hospital or a psychiatric treatment program while a member is undergoing treatment for psychiatric disorders, alcoholism or drug dependency are covered as follows.

1. Inpatient Services - Services received by a member while confined as a registered bed patient in a hospital or psychiatric treatment program will be considered covered services. The confinement must be pre-authorized by us and our Psychiatric Designee. Covered services are limited to the maximum number of inpatient days per calendar year shown on the Co-Payment Schedule. The number of days shown will be reduced by confinement in either a participating or non-participating facility provider.
2. Outpatient Services - Services received by a member while not confined in a hospital or outpatient treatment program will be considered as covered services. Covered services are limited to the maximum number of visits per calendar year and the calendar year maximum benefit shown on the Co-Payment Schedule. The number of visits shown will be reduced by visits at either a participating or non-participating provider. The outpatient treatment must be authorized by us and our Psychiatric Designee.
3. Co-Payment Amount and Percentage - All services received for the outpatient treatment of psychiatric disorders, alcoholism and drug dependency are subject to the co-payment amounts or percentages shown on the Co-Payment Schedule.

MEDICAL SERVICES (CONTINUED)

SECOND SURGICAL OPINION

No co-payment amount or percentage will apply to services received by a member for a second surgical opinion, after he or she has received a recommendation to have elective surgery which is covered under the Group Plan if:

1. the consulting physician personally examines the member and we receive a copy of the written opinion; and
2. the consulting physician does not perform the surgery to correct the condition for which the original recommendation was given.

If both the conditions stated above are not met, the Medical Services co-payment amount or percentage will be applied to the second opinion.

If the second opinion does not confirm the original recommendation, the member may consult another physician for a third opinion under the same terms and conditions as stated above for a second surgical opinion.

SECOND SURGICAL OPINION means a consultation with a Board Certified surgeon after a member has received a recommendation to have surgery. This consultation includes the physical examination, laboratory work and X-rays not previously performed by the original surgeon. The consulting surgeon must not be affiliated in practice with the surgeon who first recommended surgery.

MEDICAL SERVICES (CONTINUED)

SKILLED NURSING FACILITY SERVICES

Services received from a skilled nursing facility for room and board, and necessary services, supplies and routine care are considered covered services. The member must be confined to the skilled nursing facility as an inpatient, based upon the written recommendation of a physician. The confinement must begin within 14 days after a discharge from hospital confinement. In addition, the confinement must be due to the same condition which caused the hospital confinement or a related cause. If a member is discharged from the skilled nursing facility and again becomes an inpatient in such facility within 14 days of the original discharge, it is considered one period of confinement.

The maximum amount or co-payment percentage payable and the length of time for which we cover these services is shown on the Co-Payment Schedule.

SKILLED NURSING FACILITY means a licensed institution (other than a hospital, as defined) which meets all of the following requirements.

1. It must provide treatment to restore the health of sick or injured persons.
2. The treatment must be given by or supervised by physicians. Nursing services must be given by or supervised by registered nurses.
3. It must be eligible to qualify as a skilled nursing facility and as a provider of services under Medicare.
4. It must not primarily be a place of rest, a nursing home or a place of care for senility, drug addiction, alcoholism, mental retardation, psychiatric disorders, chronic brain syndromes or a place for the aged.
5. It must be licensed by the laws of the jurisdiction where it is located. It must be run as a skilled nursing facility as defined by those laws.

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MEDICAL SERVICES (CONTINUED)

HOSPICE SERVICES

Hospice services must be received for a hospice care program which is submitted in writing and approved by us. The member must submit his or her intent to enroll in a hospice care program approved by us in writing. Hospice services are subject to the applicable co-payment amount and percentage. The most we cover for inpatient and outpatient treatment and bereavement counseling received in a hospice care program is shown on the Co-Payment Schedule.

All outpatient hospice counseling must be received within a 12 month period. Services for bereavement counseling will be covered for counseling received during the 6 month period following the member's death.

HOSPICE CARE PROGRAM means a coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill family member and his or her covered family members, by providing palliative and supportive medical, nursing and other services through at- home or inpatient care. The hospice must be licensed by the laws of the jurisdiction where it is located and must be run as a hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illness and, as estimated by a physician, are expected to live less than 6 months as a result of that illness.

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ORGAN TRANSPLANT BENEFIT

Contrary to any limitations on organ transplants contained in the Group Plan, we will pay benefits for covered organ transplant expenses, as defined below, incurred by a member for an organ transplant approved by us at a facility approved by us, subject to those conditions and limitations described below.

TRANSPLANT means pre-transplant, transplant inclusive of any chemotherapy and associated services and post-discharge services, and treatment of complications after transplantation. We will pay benefits only for services, care, and treatment received for or in connection with the approved transplantation of the following human organs:

1. Heart;
2. Liver, for the following diagnoses: Biliary Atresia, Primary Biliary Cirrhosis, Primary Sclerosing Cholangitis, Postnecrotic Cirrhosis Hepatitis B Surface Antigen Negative, Alcoholic Cirrhosis (only if 6 months abstinence from alcohol is documented), Alpha-1 Antitrypsin Deficiency Disease, Wilson's Disease, Primary Hemochromatosis. Diagnoses not covered for liver transplantation include, but are not limited to, the following diagnoses: Primary or Metastatic Cancer of the Liver, Hepatitis B Surface Antigen Positive, Secondary Biliary Cirrhosis, Lupus Hepatitis or Autoimmune Hepatitis, Cytomegalovirus Hepatitis, Epstein-Barr Virus Hepatitis, Budd-Chiari Syndrome, Veno-Occlusive Disease, Liver damage caused by chemicals, toxins, or external agents, Alcoholic Cirrhosis without 6 months abstinence from Alcohol;
3. Kidney;
4. Bone marrow (allogeneic, autologous and peripheral blood stem cells) but only for certain types of Leukemia, Neuroblastomas, Lymphomas, Ewing's Sarcoma, Aplastic Anemia, Wiskott-Aldrich Sydrome, Severe Combined Immuno-Deficiency Syndrome. We will not cover bone marrow transplants (allogeneic, autologous or peripheral blood stem cells) for treatment of cancers or diseases of the brain, breast, bone, large bowel, ovary, small bowel, testicle, esophagus, kidney, liver, lungs, pharynx, prostate, skin, connective tissue and uterus. We will not cover bone marrow transplants for any congenital, genetic or metabolic disorders affecting or originating in the blood-forming (hematopoietic) system except as stated above as covered.

Corneal transplants, which are tissues rather than organs, do not required prior approval.

As used in this document, the term "bone marrow transplant" means human blood precursor cells which are administered to a patient following ablative or myelosuppressive therapy. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "bone marrow transplant" includes the harvesting, the transplantation and the chemotherapy components.

For a transplant procedure to be considered approved for this Transplant Benefit, prior approval from our Medical Affairs Department is required in advance of the procedure. You or your Physician must notify us in advance of your initial evaluation for the procedure in order for us to determine if the transplant services will be covered. For approval of the transplant itself, our Medical Affairs Department must be given the opportunity to evaluate the clinical results of the evaluation. Approval will be based on written criteria and procedures established by our Medical Affairs Department. If approval is not given, benefits will not be provided for the transplant procedure as defined above.

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EXCLUSIONS

No benefit is payable for or in connection with a transplant if:

1. The organ or diagnosis involved is not listed in this section of the Group Plan. Transplants that are not covered include, but are not limited to, islet cells, lung(s), heart-lung combination, pancreas, kidney-pancreas combination, bowel, stomach, thymus, and pituitary. Bone Marrow and liver transplants are also excluded except as stated as covered in this Group Plan.
2. Our Medical Affairs Department is not contacted for authorization prior to referral for transplant evaluation of the procedure.
3. Our Medical Affairs Department does not approve coverage for the procedure, based on our established criteria.
4. The transplant procedure is performed in a facility that has not been designated by our Medical Affairs Department as an approved transplant facility.
5. Expenses are eligible to be paid under any private or public research fund, government program, or other funding program, whether or not such funding was applied for or received.
6. The expense relates to the transplantation of any non-human organ or tissue.
7. The expense relates to the donation or acquisition of an organ for a recipient who is not covered by us.
8. A denied transplant is performed; this includes the transplant procedure, follow up care, immumo-suppressive drugs, and complications of such transplant.

The following services/supplies/expenses are also not covered:

1. Artificial heart devices used as a bridge to transplant.
2. Drugs used in connection with diagnosis or treatment leading to a transplant when such drugs have not received FDA approval for such use.

Once the transplant procedure is approved, our Medical Affairs Department will advise the member's physician of those facilities that have been approved for the type of transplant procedure involved. Benefits are payable only if the pre-transplant services, the transplant procedure and post-discharge services are performed in an approved facility.

COVERED EXPENSES

For approved transplant procedures, and all related complications, we will cover only the following expenses:

1. Hospital expenses and physician's expenses will be paid under the Hospital Benefit and Physician's Benefit in this Group Plan in accordance with the same terms and conditions as we will pay benefits for care and treatment of any other covered injury or sickness.
2. Transportation costs for the member to and from the approved facility where the transplant is to be performed if the facility is more than 100 miles from the member's home.
3. Direct, non-medical costs for one member of the member's immediate family (two members if the patient is under age 18 years) for (a) transporation to and from the approved facility where the transplant is performed, but no more than one round trip per person per transplant and (b) temporary lodging at a prearranged location during the member's confinement in the approved transplant facility, not to exceed $75 per day. Direct, non-medical costs are only payable if the member lives more than 100 miles from the approved transplant facility. There is a $5000 maximum for these direct, non-medical expenses.
4. Organ acquisition and donor costs. However, donor costs are not payable under the Group Plan if they are payable in whole or in part by any other group plan, insurance company, organization or person other than the donor's family or estate.

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EXCLUSIONS AND LIMITATIONS

PRE-EXISTING CONDITION LIMITATION: Services for pre-existing conditions are not covered until the earlier of the following dates:

1. the date the member has been free of treatment for the pre-existing condition for three consecutive months; or
2. the date the member has been covered by the Group Plan for 12 consecutive months.

PRE-EXISTING CONDITION means a condition which:

1. is caused by an injury or sickness; and
2. required a member, during the three months prior to becoming covered, to:
   a. consult a physician;
   b. seek diagnosis or advice or receive medical care or treatment;
   c. undergo hospital admission or physician visits for testing or diagnostic studies; or
   d. obtain services, supplies, prescription drugs or medicines.

OTHER LIMITATIONS AND EXCLUSIONS:

Unless specifically stated otherwise, no services will be provided or paid for or on account of:

1. a sickness or injury which is covered under any Workers' Compensation or similar law.
2. care and treatment given in a hospital owned or run by any federal, state, or other government, unless the member is legally required to pay for such care and treatment. However, care and treatment provided by military hospitals to armed services retirees and their dependents is not excluded.
3. any charge which would not have been made if the member had no coverage or any charge the member would not be legally required to pay.

4. sickness or injury for which the member is in any way paid or entitled to payment or care and treatment by or through a government program, other than Medicaid.

5. education or training; medical services provided by the member's parent, spouse, brother, sister, or child.

6. experimental or investigational drugs or substances not approved by the Food and Drug Administration; drugs or substances used for other than Food and Drug Administration approved indications; or drugs labeled: "Caution-limited by Federal law to investigational use".

7. prescription drugs, including insulin and syringes, vitamins, birth control pills unless medically necessary for a medical condition and non-prescription drugs or medicines.

8. treatment, services, supplies or surgery that is not medically necessary.

9. the purchase or fitting of hearing aids or advice on their care; implantable hearing devices.

10. weekend non-emergency hospital admissions.

11. in-vitro fertilization; any medical or surgical treatment of infertility; infertility evaluations; sex change services; or reversal of elective sterilization.

12. any drug, biological product, device, medical treatment, or procedure which is experimental or investigational that is defined in this Group Plan; any drug, biological product, device, medical treatment or procedure which is not covered as experimental or investigational (or similar) by the HCFA Medicare Coverage Issues Manual; any drug, biological product, or device which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and which lacks such approval at the time of its use or proposed use; or, any drug or biological product categorized as a Treatment Investigational New Drug (IND) by the U.S. Food and Drug Administration or as a Group C Treatment Protocol drug by the U.S. National Cancer Institute at the time of its use or proposed use. Specifically excluded are: ambulatory blood pressure monitor, refractive keratoplasty or radial keratotomy, positron emission tomography (PET) scans, transurethal balloon dilation of prostate, immunotherapy for recurrent abortion, chemonucleolysis, biliary lithotripsy, home uterine activity monitor, immunotherapy for food allergy, and percutaneous lumbar discectomy.

13. plastic, cosmetic or reconstructive surgery unless medically necessary as the result of an injury or tumor. The injury, or the initial tumor surgery, must occur while insured under the Group Plan. Such surgery will also be covered if an objective functional impairment is present. An objective functional impairment is defined as a direct measurable reduction of physical performance of an organ or body part. The presence of a psychological condition will not entitle a member to coverage for plastic, cosmetic or reconstructive surgery unless all other conditions are met.

14. services and supplies for dental services, treatment of teeth or periodontium, oral surgery, or any other orthodontic treament regardless of medical neccesity, unless (a) the services and supplies are for the treatment of temporomandibular joint (TMJ) syndrome/dysfunction or craniomandibular jaw disorder (CMJ); or (b) the services are required due to the surgical removal of a tumor or lesion in the mouth, or (c) the services are received in connection with an injury to sound natural teeth or jaw sustained while the person is covered by the Group Plan if (1) the care and treatment is provided within 12 months from the date of the injury, (2) the member is continuously covered under the Group Plan from the date of the injury to the date care and treatment is received, and (3) the injury was not the result of biting or chewing. We will not cover dental braces, dental implants or any treatment related to the preparation or the fitting of dentures.

15. services and supplies for treatment of temporomandibular joint (TMJ) syndrome/dysfunction and craniomandibular jaw disorder (CMJ) which are recognized as dental procedures. This includes, but is not limited to, the extraction of teeth and the application of orthodontic devices and splints.

16. diagnosis or care and treatment of: (a) weak, strained, unstable or flat feet; or (b) toenails, except removal of a nail matrix.

17. any: (a) superficial lesions of the feet, such as corns, calluses or hyperkeratoses; or (b) tarsalgia, metatarsalgia or bunion, except surgery which involves exposure of bones, tendons or ligaments.

18. for any service, supply or treatment connected with custodial care. We do not provide these services no matter who provides, prescribes, recommends or performs them. Custodial care means services designed to help a member meet the needs of daily living, whether or not he or she is disabled. These services include help in:

    a. walking or getting in or out of bed;
    b. personal care such as bathing, dressing, eating, or preparing special diets; or
    c. taking medication which the member would normally be able to take without help.

19. sickness or injury caused by: (a) war, whether or not declared, or insurrection; or (b) military service.

20. sickness or injury caused by the member's: (a) engaging in an illegal occupation; or (b) commission of or an attempt to commit a criminal act.

21. enrollment in a health, athletic, or similar club; or a weight loss or similar program.

22. purchase or rental of supplies of common household use such as: exercise cycles; air purifiers; central or unit air conditioners; water purifiers; allergenic pillows or mattresses; or waterbeds.

23. purchase or rental of: motorized transportation equipment; escalators or elevators; saunas or swimming pools; professional medical equipment such as blood pressure kits; or supplies or attachments for any of these items.

24. convenience or personal care services such as use of a telephone or television.

25. any surgical procedure to reduce obesity.

26. elective abortion unless the physician certifies in writing that the pregnancy would endanger the life of the mother.

27. pregnancy of a child, except: complications arising from it; or for pregnancies resulting from rape or incest.

28. vision analysis, testing or orthoptic training or the purchase of eyeglasses or contact lenses.

29. spinal manipulations.

30. services and supplies which are (a) rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services, (b) extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation, or (c) for marriage counseling, when such services extend beyond the period necessary for short-term evaluation or crisis intervention, or (d) for mental illnesses which, according to generally accepted professional standards, are not usually amendable to favorable modification.

31. acupuncture, unless:

    a. the treatment is medically necessary and appropriate and is provided within the scope of the acupuncturist's license;
    b. the insured person is referred to the acupuncturist's treatment by a licensed physician; and
    c. the acupuncture is performed in lieu of generally accepted anesthesia practices.

32. routine physical examinations, even when required by an employer, school or insurance company.

33. services related to methadone treatment and care related to a dependency created by the use of methadone.

34. court ordered treatment for psychiatric disorders, alcoholism and drug dependency.

35. any and all benefits related to organ or artificial organ transplants or organ donations, except as specifically provided in the Organ Transplant Benefit section of this Group Plan.

36. maintenance care, which consists of services and supplies furnished mainly to:

    a. maintain, rather than improve, a level of physical or mental function; or
    b. provide a protected environment free from exposure that can worsen the member's physical or mental condition.

37. care and treatment rendered by a provider whose services are not required to be covered by state law, except as provided by the Group Plan.

38. care and treatment of complications of non-covered procedures, unless required by state law.

39. more than one prescription for the same drug or therapeutic generic medication prescribed by one or more physicians and dispensed by one or more pharmacies until at least 75% of the previous prescription has been used by the member. (Based on the dosage schedule prescribed by the physician.)

40. services provided prior to the effective date or after the termination of your coverage under the Group Plan. Coverage will be extended under the Extension of Health Services provision, if such coverage is required by state law.

EMERGENCY COVERAGE AT NON-PARTICIPATING PROVIDERS

Subject to any co-payments and maximum limitations for the services received as described in the Co-Payment Schedule for this Health Services Agreement, we will reimburse or pay on behalf of a member the emergency services expense he or she incurs for covered health services received from a non-participating provider on the same basis as covered services received from a participating provider, if we authorize the services as described in this section. Our reimbursement or payment will be reduced by any co-payments which would have been required had the services been provided by a participating provider.

All such expenses:

1. must have been incurred for medically necessary services;
2. must have been incurred or provided under the order, direction and approval of a licensed physician; and
3. must not exceed reasonable charges for the services.

Payment for emergency services received at non-participating providers will be subject to the following:

1. IN THE SERVICE AREA, the member must contact his or her physician before receiving services.

   If the member is unable to contact his or her physician, the member must go to the nearest participating hospital.

   If the member is unable to indicate a choice of hospital, or if travel to the nearest participating hospital would endanger the member, the member should:

   a. receive emergency services; and
   b. notify us of the emergency within 24 hours of the time emergency services are received, or as soon after that as is reasonably possible. Notification must include full details of the care provided and to be provided to the member.

If we then determine that the sickness or injury was not serious enough to warrant coverage as an emergency, or if the member does not notify us as described above, the services received will be payable as covered services received from a non-participating provider.

2. OUTSIDE THE SERVICE AREA: If emergency services are required and the member cannot reasonably return to the service area, the member should:

   a. receive emergency services; and
   b. notify us of the emergency within 48 hours of the time emergency services are received, or as soon after that as is reasonably possible. Notification must include full details of the care provided and to be provided to the member.

   If we then determine that the sickness or injury was not serious enough to warrant coverage as an emergency, or if the member does not notify us as described above, the services received will be payable as covered services received from a non-participating provider.

   In any event, the member is responsible for any amount we determine is in excess of reasonable charges.

3. FOLLOW-UP CARE to the emergency services must be received from participating providers as soon as it is reasonably possible to so provide the care. Care received from non-participating providers after the emergency ceases to exist will be covered as any other service received from a non-participating provider.

4. DEPENDENTS WHO ARE STUDENTS outside of the service area are subject to the terms and conditions of this Emergency Coverage at Non-Participating Providers provision.

PRESCRIPTION DRUG COVERAGE RIDER

The following terms are used in this coverage description.

FORMULARY means a list of drug products, including their strengths and appropriate dosages, that are available for use by members.

NON-PARTICIPATING PHARMACY means a pharmacy that has not entered into a service agreement with us.

PARTICIPATING PHARMACY means a pharmacy which agrees to provide service under terms set forth by us.

PHARMACIST means a person who is licensed to prepare, compound and dispense medication and who is practicing within the scope of his or her license.

PHARMACY means a licensed establishment where prescription medications are dispensed by a pharmacist.

PRESCRIPTION means a direct order for the preparation and use of a drug, medicine or medication. This order may be given by a physician to a pharmacist for the benefit of and use by a member. The drug, medicine or medication must be obtainable only by prescription. The prescription may be given to the pharmacist verbally or in writing by the physician. The prescription must include:

1. the name and address of the member for whom the prescription is intended;
2. the type and quantity of the drug, medicine or medication prescribed, and the directions for its use;
3. the date the prescription was prescribed; and,
4. the name, address and DEA number of the prescribing physician.

COVERAGE DESCRIPTION

We will cover prescription drugs that are received by the member while he or she is covered under this Prescription Drug Coverage Rider of the Group Plan as follows.

Covered prescription drugs are:

1. any drug, medicine or medication that, under Federal or state law, may be dispensed only by prescription from a physician, or any compounded prescription containing such drug, medicine or medication; and;
2. insulin, hypodermic needles or syringes on prescription.

Covered prescription drugs must:

1. be prescribed by a participating physician for the treatment of an injury or sickness;
2. be dispensed by a pharmacist; and
3. be a generic medication when both a generic and a more expensive brand name drug are available; and
4. be included in the formulary approved by us.

Contrary to any other provisions of the Group Plan, prescription drugs provided under this Prescription Drug Coverage Rider are not provided under any other provision in the Group Plan. Any prescriptions ordered or received to the extent they are in excess of any maximums covered under this Agreement are not covered under any other provision in the Group Plan.

The member's ID card must be presented to a participating pharmacy each time a prescription is filled or refilled.

PRESCRIPTION DRUG CO-PAYMENT

The prescription drug co-payment for a participating pharmacy is $5
. It must be paid by the member each time a prescription is filled or refilled. The prescription drug co-payment by the member is not covered by this or any other provision of the Group Plan.

In addition to the deductible, the member must pay the participating pharmacy 100% of the additional cost for a more expensive brand name prescription drug, which is dispensed at the request of the member or the prescribing physician, when a generic is available, unless the brand name drug is specifically authorized by the prescribing physician.

LIMITATIONS AND EXCLUSIONS

Unless specifically stated otherwise, no services are provided for:

1. any drug, medicine or medication that is consumed at the place where the prescription is given or that is dispensed by a participating physician;
2. any portion of a prescription or refill that exceeds a 34-day supply or a 100 unit dose, whichever is less;
3. prescription refills in excess of the number specified by the participating physician or dispensed more than one year from the date of the participating physician's original order;
4. the administration of covered medication;
5. prescriptions that are to be taken by or administered to the member, in whole or in part, while he or she is a patient in a hospital, rest home, skilled nursing facility, convalescent hospital, inpatient hospice facility or other facility where drugs are ordinarily provided by the facility on an inpatient basis;

6. prescriptions that may be properly received without charge under local, state or federal programs, including Workers' Compensation;
7. any drug, medicine or medication labeled "Caution–Limited by Federal Law to Investigational Use" or any experimental drug, medicine or medication, even though a charge is made to the member;
8. immunizing agents, biological serums or allergy serums;
9. any drug or medicine that is lawfully obtainable without a prescription;
10. any drug, medicine or medication received by the member before becoming covered by this Prescription Drug Coverage Rider, or after the date the member's coverage under this provision has ended;
11. therapeutic devices or appliances, including support garments, and other non-medical substances, regardless of intended use;
12. hypodermic needles or syringes, unless prescribed and dispensed in conjunction with a prescribed medication. The hypodermic needles or syringes must be dispensed at the same time as the medication and in like quantity;
13. more than one prescription for the same drug or therapeutic equivalent medication prescribed by one or more physician and dispensed by one or more pharmacies until at least 75% of the previous prescription has been used by the member. (Based on the dosage schedule prescribed by the physician.)
14. any contraceptives, regardless of intended use;
15. injectable medication, except insulin on prescription;
16. any costs related to the mailing, sending or delivery of prescription drugs; and
17. prescriptions filled at a non-participating pharmacy, except for prescriptions required during an emergency.

CO-PAYMENT SCHEDULE

PERCENTAGE CO-PAYMENTS SHOW THE PERCENTAGE OF REASONABLE CHARGES WE WILL PAY. PARTICIPATING PHYSICIANS HAVE AGREED TO ACCEPT OUR REASONABLE CHARGE DETERMINATION AS PAYMENT IN FULL. SEE PAGE HP2108 FOR THE DEFINITION OF 'REASONABLE CHARGES.'

INDIVIDUAL LIFETIME MAXIMUM COVERED SERVICES AMOUNT ——— $1000000

MEDICAL SERVICES CO-PAYMENT AMOUNTS

Calendar Year Co-Payment Amount For Each Member ——— $150
Calendar Year Co-Payment Amount For Each Family of Members ——— $450

MEDICAL SERVICES	CO-PAYMENT AMOUNT APPLICABLE	OUR CO-PAYMENT PERCENTAGE PAYABLE AFTER CO-PAYMENT AMOUNT
Room and Board and Ancillary Services at Semi-Private Room Rate		
- Participating Hospital	YES	80 %
- Non-Participating Hospital	NOT COVERED	NOT COVERED
Outpatient Non-Surgical Services		
- Participating Hospital	YES	80 %
- Non-Participating Hospital	NOT COVERED	NOT COVERED
Outpatient Surgical Services		
- Participating Hospital	YES	80 %
- Non-Participating Hospital	NOT COVERED	NOT COVERED
Pre-Admission Testing in Accordance with Group Plan Provisions	NO	100%

CO-PAYMENT SCHEDULE (CONTINUED)

MEDICAL SERVICES	CO-PAYMENT AMOUNT APPLICABLE	OUR CO-PAYMENT PERCENTAGE AFTER CO-PAYMENT AMOUNT
Emergency Room Visit (Facility Charge)		
- Participating Hospital	$40	80 %
- Non-Participating Hospital	$40	80 %*

*Medical emergencies are covered at the participating hospital benefit level. No benefits are covered if there is not a medical emergency.

WAIVER OF NON-PARTICIPATING HOSPITAL EXCLUSION

Services will be covered in non-participating hospitals in the following circumstances:

HOSPITAL SERVICES	CO-PAYMENT AMOUNT APPLICABLE	OUR CO-PAYMENT PERCENTAGE AFTER CO-PAYMENT AMOUNT
- Emergency Services Rendered Outside the Service Area	- SEE PARTICIPATING HOSPITAL BENEFIT LEVELS -	
- Services Not Available at a Participating Hospital	- SEE PARTICIPATING HOSPITAL LEVELS -	

CO-PAYMENT SCHEDULE (CONTINUED)

MEDICAL SERVICES	CO-PAYMENT AMOUNT APPLICABLE	OUR CO-PAYMENT PERCENTAGE AFTER CO-PAYMENT AMOUNT
Office Visits (1)		
- Participating Physician	$ 10 Co-Payment Per Visit	100%
- Non-Participating Physician	Medical Services Co-Payment	80 %
Allergy Immunizations		
- Participating Physician	$3 Co-Payment Per Visit	100%
- Non-Participating Physician	Medical Services Co-Payment	80 %
Inpatient Services (2)		
- Participating Physician	NO	80 %
- Non-Participating Physician	Medical Services Co-Payment	80 %
Outpatient Services		
- Participating Physician	NO	80 %
- Non-Participating Physician	Medical Services Co-Payment	80 %

(1) Includes emergency room visits by the physician and minor diagnostic and therapeutic procedures performed in the physician's office.

(2) If a participating physician admits you to a non-participating provider or performs outpatient surgery at a non-participating provider, coverage for Physician Services will be reduced by 20%, unless the services at the non-participating provider were required because of a medical emergency or because the service was not available at a participating provider.

CO-PAYMENT SCHEDULE (CONTINUED)

MEDICAL SERVICES	CO-PAYMENT AMOUNT APPLICABLE	OUR CO-PAYMENT PERCENTAGE AFTER CO-PAYMENT AMOUNT
Ambulance Services		
- Participating	YES	80 %
- Non-Participating	YES	60 %
Hospice Care Services		
- Inpatient	YES	$150 per day up to a maximum benefit of $3000
- Outpatient	YES	$50 per visit up to a maximum benefit of $2000
All Other Medical Services Including Services/Supplies Not Available at Participating Providers	YES	80 %

CALENDAR YEAR CO-PAYMENT LIMITS FOR PARTICIPATING HOSPITAL, ALL PHYSICIAN PROVIDERS AND MEDICAL SERVICES (Excludes any initial co-payment amounts)

Each Member $500
Each Family of Members $1500

PRE-AUTHORIZATION PENALTY

If any required pre-authorization of services is not obtained, coverage for any medically necessary services, after any applicable co-payments, will be reduced by 50%. If services are not medically necessary, no coverage is provided at all. This out-of-pocket amount may not be used to satisfy any Co-Payment Limits.

HHPHCR11

HUMANA HEALTH PLAN, INC.

ACCIDENT RIDER

This Rider modifies your coverage as follows:

We will provide or pay 100% of the first $200 of covered services received for the treatment of an accidental injury. Treatment must be provided within 72 hours of the injury.

We will also cover related services received within 90 days of the date the injury occurred.

This coverage is not subject to a co-payment amount.

Any services provided or paid under this Rider are not covered under any other section of the Group Plan.

HUMANA HEALTH PLAN, INC.

President

HHPHCR12

WELLNESS RIDER

Contrary to any exclusions in the Group Plan, we will pay benefits for one detailed office visit per calendar year for a clinical exam and health counseling, which includes a pap smear and total blood cholesterol screening received by an insured over 2 years of age from a physician.

Detailed Office Visit

Participating Physician	Benefit payable same as shown in the Co-Payment Schedule for Participating Physician Office Visit. Member's initial/annual co-payments and per occurrence co-payments apply, if any.
Non-Participating Physician	Not Covered

Any initial/annual or per occurrence co-payments incurred under this Rider will not apply to the member's Maximum Co-Payment Limit(s).

President

HHPHCR13

WELL CHILD CARE RIDER

Contrary to any exclusions in the Group Plan, we will pay benefits for outpatient preventive well-child care for a covered dependent child to two (2) years of age.

Outpatient preventive well-child care means the charges made by a personal physician for routine pediatric exams and immunizations given to a child as recommended by the American Academy of Pediatrics for children to two (2) years of age. This will be limited to three (3) exams between a child's birth and the first twelve (12) months and two (2) exams between twelve (12) months and the child's second birthday.

Participating Physician	Benefit payable same as shown in the Co-Payment Schedule for Participating Physician Office Visit. Member's initial/annual co-payments and per occurrence co-payments apply, if any.
Non-Participating Physician	Not Covered

Any initial/annual or per occurrence co-payments incurred under this Rider will not apply to the member's Calendar Year Co-Payment Limit(s).

President

AMENDMENT

Humana Health Plan, Inc.
500 West Main Street, Louisville, Kentucky 40202

GROUP PLAN SPONSOR:

HEALTHCARE RECOVERIES, INC.

GROUP PLAN NUMBER: 41308

The Group Plan is amended as set forth in this Amendment, effective as of its renewal date on or after July 15, 1996.

I. **The DEFINITIONS Section on page HP2107.01 is amended by adding the following new language:**

- PROVIDER - means a facility or professional practitioner that is licensed according to law in the jurisdiction in which it, he, or she is located or practices. With respect to a professional practitioner, he or she must be practicing within the scope of license and the services involved must be required to be covered by the laws of the jurisdiction where the treatment is performed. A licensed Ophthalmic Dispenser, Chiropractor, Certified Psychologist, or Psychological Associate is considered a Provider.

II. **The MEDICAL SERVICES Section on page HP7401.03 is amended by adding the underlined new language, as follows:**

7. Obstetrical services received on an inpatient or outpatient basis, including medically necessary prenatal and post-natal care of the mother,

Semi-private accommodations.
Coverage will be provided for:

a. for inpatient care for a mother and her newly-born child for a minimum of forty-eight (48) hours after vaginal delivery and a minimum of ninety-six (96) hours after delivery by Cesarean section; or

b. for a shorter length of stay, with the consent of the mother, if the Physician determines that the mother and the newborn meet medical stability criteria and the Plan authorizes an initial postpartum Home Health Care visit which includes the collection of an adequate sample for hereditary and metabolic newborn screening.

III. **The LIMITATIONS AND EXCLUSIONS Section on page HP7503 is amended to delete reference to the words "and splints" under exclusion 15. The new language will read as follows:**

15. Services and supplies for treatment of temporomandibular joint (TMJ) syndrome/dysfunction and craniomandibular jaw disorder (CMJ) which are recognized as dental procedures. This includes, but is not limited to, the extraction of teeth and the application of orthodontic devices.

IV. The OPTIONAL CONTINUATION OF HEALTH SERVICES COVERAGE Section on pages HP4008.02KY and HP4009, is amended by adding the underlined new language, as follows:

If you are no longer eligible for coverage under the Health Services Agreement of the Group Plan, you may choose to continue these services for up to 18 months after the date your coverage terminates. You must give us written notice of your choice to continue coverage within 31 days after you are given proper notice of your right to continuation.

Continued coverage terminates on the earliest of the following dates: (1) the last day of the 18 month period following the date you were no longer eligible for coverage; (2) the date you became covered for similar group benefits, either on an insured or uninsured basis; (3) the date you fail to make any required subscription fee contribution; (4) the date you reach your Lifetime Maximum Covered Services Amount; or (5) the date the Group Plan terminates and is not replaced by similar group benefits within 31 days.

V. THE ORGAN TRANSPLANT BENEFIT Section on page HP7418 is amended by adding the underlined new language, as follows:

4. Bone marrow (allogeneic, autologous and peripheral blood stem cells) for Wiskott-Aldrich Syndrome, Severe Combined Immunodeficiency Syndrome, Leukemia, Lymphoma, Aplastic Anemia, Ewing's Sarcoma, Neuroblastomas and breast cancer by high-dose chemotherapy (if performed in compliance with the applicable guidelines of the American Society of Blood and Marrow Transplantation and/or the International Society of Hematotherapy and Graft Engineering). We will not cover bone marrow transplants (allogeneic, autologous or peripheral blood stem cells) for treatment of cancers or diseaseas of the brain, bone, large bowel, ovary, small bowel, testicle, esophagus, kidney, liver, lungs, pharynx, prostate, skin, connective tissue and uterus. We will not cover bone marrow transplants for any congenital, genetic or metabolic disorders affecting or originating in the blood-forming (hematopoietic) system except as stated above as covered.

VI. The TERMINATION FOR CAUSE Section on page HP4002 is amended by adding the underlined new language, as follows:

- **We will terminate a member's coverage for cause under the following circumstances:**

  5. **If a Member or group perpetrates fraud and/or misrepresentation on claims or identification cards in order to obtain services or a higher level of benefits, or the intentional and abusive non-compliance with the provisions of this Group Plan by the member as determined by the Plan. This includes, but is not limited to, the fabrication and/or alteration of a claim or identification card.**

HPSA0213

LOUISVILLE SERVICE AREA

Bullitt County, Kentucky
(Total County - All Zip Codes)

Carroll County, Kentucky
(Total County - All Zip Codes)

Henderson County, Kentucky
(Total County - All Zip Codes)

Henry County, Kentucky
(Total County - All Zip Codes)

Jefferson County, Kentucky
(Total County - All Zip Codes)

Marion County, Kentucky
(Total County - All Zip Codes)

McLean County, Kentucky
(Total County - All Zip Codes)

Meade County, Kentucky
(Partial County - See Zip Code(s) Below)

ZIP Code	Area	ZIP Code	Area
40108	Brandenburg	40155	Muldraugh

Nelson County, Kentucky
(Total County - All Zip Codes)

Oldham County, Kentucky
(Total County - All Zip Codes)

HPSA0214

LOUISVILLE SERVICE AREA (CONTINUED)

Shelby County, Kentucky
(Total County - All Zip Codes)

Spencer County, Kentucky
(Total County - All Zip Codes)

Taylor County, Kentucky
(Total County - All Zip Codes)

Trimble County, Kentucky
(Total County - All Zip Codes)

Union County, Kentucky
(Total County - All Zip Codes)

Washington County, Kentucky
(Total County - All Zip Codes)

Webster County, Kentucky
(Total County - All Zip Codes)

Clark County, Indiana
(Total County - All Zip Codes)

Crawford County, Indiana
(Total County - All Zip Codes)

Floyd County, Indiana
(Total County - All Zip Codes)

HPSA0216

LOUISVILLE SERVICE AREA (CONTINUED)

Harrison County, Indiana
(Total County - All Zip Codes)

Jackson County, Indiana
(Total County - All Zip Codes)

Jefferson County, Indiana
(Total County - All Zip Codes)

Jennings County, Indiana
(Total County - All Zip Codes)

Orange County, Indiana
(Total County - All Zip Codes)

Scott County, Indiana
(Total County - All Zip Codes)

Washington County, Indiana
(Total County - All Zip Codes)

PHYSICIAN AND MEDICAL SERVICES NUMBER

(In Louisville) 580-5050
(Toll-Free) 1-800-448-0222

CLAIMS NUMBER

(Claims status, benefits, I.D. cards, enrollment and eligibility status)

(In Louisville) 580-5100
(Toll-Free) 1-800-992-0678

Kentucky Physicians Plan℠ 620

Humana Health Care Plan

You receive quality coverage at participating hospitals and enhanced coverage by using participating physicians.

Hospital services

Participating hospital services	Plan provides:
■ Inpatient care	80 percent* of reasonable charges after initial annual copaymer
■ Outpatient surgery	80 percent* of reasonable charges after initial annual copaymer
■ Outpatient non-surgical	80 percent* of reasonable charges after initial annual copaymer
■ Hospital emergency room (when not admitted)	80 percent* of reasonable charges after $40 copayment per visi (initial annual copayment does not apply)

Participating hospitals include:

Audubon Regional Medical Center
Southwest Hospital
Suburban Medical Center
University of Louisville Hospital

Physician services

Physician services	Enhanced coverage (participating physician) Plan provides:	Basic coverage (non-participating physician) Plan provides:
■ Office visits for treatment of an injury or illness, including emergency room visits (routine physical exams and outpatient surgery are not covered)	100 percent of reasonable charges after $ 10 copayment per visit	80 percent* of reasonable charges after initial annual copayment
■ Diagnostic testing, x-rays, laboratory tests and allergy testing performed in the physician's office (excluding CAT scans and MRI procedures, which are covered under Other medical services)	100 percent of reasonable charges after satisfying the office visit copayment	80 percent* of reasonable charges after initial annual copayment
■ Allergy injections	100 percent of reasonable charges after $3 copayment per injection	80 percent* of reasonable charges after initial annual copayment
■ Inpatient	80 percent* of reasonable charges (initial annual copayment does not apply)	80 percent* of reasonable charges after initial annual copayment
■ Outpatient (includes surgery performed in the physician's office)	80 percent* of reasonable charges (initial annual copayment does not apply)	80 percent* of reasonable charges after initial annual copayment

*Copayment percentage is applied toward the maximum annual out-of-pocket member expense limit.

Coverage is not provided for non-participating hospital services, except for life- or limb-threatening emergencies or servic not available (prior plan approval required).

Kentucky Physicians Plan gives you a toll-free number for claims and enrollment questions.

Note: Participating hospitals, physicians and providers have agreed to accept our reasonable charge determination as payment in full.

GHC KY-1014

Other medical services

Covered services are subject to:

Initial annual copayment (excludes per visit copayments)	Individual: $ 150 Family: $ 450
Regular copayment	Plan member pays 20 percent up to maximum annual out-of-pocket member expense limit after initial annual copayment
Maximum annual out-of-pocket member expense limit (excludes initial annual copayment and any per visit copayments)	Individual: $ 500 Family: $ 1500

Other medical services include, but are not limited to, covered hospital and physician services not specified elsewhere in the plan as well as the following services:

	Participating provider	Non-participating provider
■ Home health care (up to 60 visits per calendar year)	80 percent of reasonable charges after initial annual copayment	60 percent of reasonable charges after initial annual copayment
■ Durable medical equipment	80 percent of reasonable charges after initial annual copayment	60 percent of reasonable charges after initial annual copayment
■ Ambulance	80 percent of reasonable charges after initial annual copayment	60 percent of reasonable charges after initial annual copayment
■ Skilled Nursing Facility (up to 60 days per calendar year)	80 percent of reasonable charges after initial annual copayment	60 percent of reasonable charges after initial annual copayment
■ Prescription drugs (if drug rider is not included)	80 percent of reasonable charges after initial annual copayment	80 percent of reasonable charges after initial annual copayment

NOTE: Please call the customer service office for information on participating providers: 580-5050

■ Mental and nervous disorders (includes alcoholism and chemical dependency) — Please see separate sheet for coverage details.

Optional coverages
Optional riders are available with this plan.
Please see separate sheets for coverage details.

Maximum lifetime benefit: $1 million

This is a brief plan description. It is not the plan document, and does not include all of the benefits, limitations and exclusions of the plan. Complete terms of the plan are contained in the Group Plan Documents.

GHC KY-1014/1015/1016/1017

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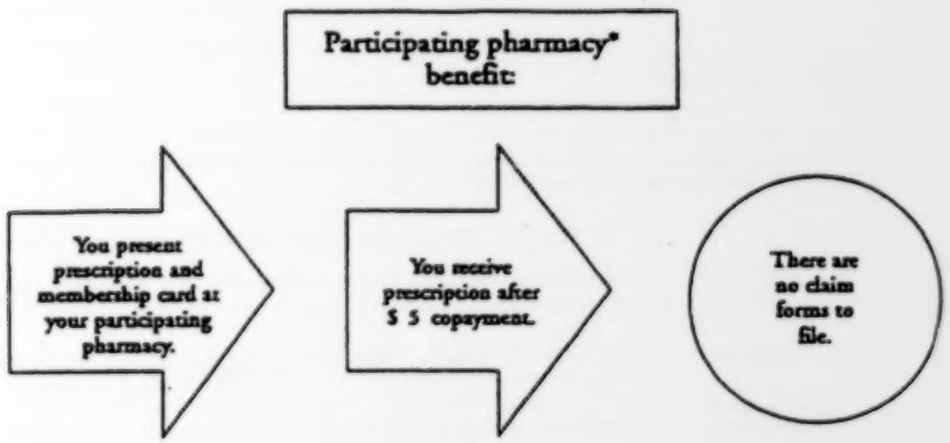
Prescription drug coverage (optional) (PPO)

Humana Health Care Plans

$ 5 copayment per prescription at participating pharmacies.*



*Note: For a complete listing of the participating pharmacies in your area, please refer to the participating provider listing.

Prescription coverage is for 100 units or 34-day supply, whichever is less, per prescription or refill.

Please note that generic medication will be used when available. If you prefer a brand name medication when a generic is available, you must pay 100 percent of the additional cost as well as the copayment. If no generic is available, you will receive the brand name medication for only the copayment.

Please refer to the Certificate of Coverage for complete details regarding prescription drug coverage.

GHC KY-0812

In Indiana: Offered and underwritten by Humana Insurance Company
In Kentucky: Offered by Humana Health Plan, Inc.
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PPO
Louisville
S. IN
N. KY
Lexington
1093

Kentucky Physicians Plan℠ for Kentucky and Indiana Accidental injury coverage

Humana Health Care Plans

Accidental injury coverage at 100 percent of the first $200

Coverage includes eligible facility, physician's office and physician charges up to a specified amount.

Initial treatment must begin within 72 hours of the date of the accident.

Includes follow-up treatment, related to the injury, received within 90 days of the date of the accidental injury.

GHC KY-0821

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In Kentucky: Offered by Humana Health Plan, Inc.
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KY
S. IN
1093

How to handle emergencies when out of the service area using your Kentucky Physicians Plan

What is an emergency?

A true medical emergency is an accident or illness that is of unpredictable onset and which produces severe pain, loss of consciousness, excessive bleeding or poses an immediate threat to life or limb. For exact specifications regarding emergency coverage, please refer to your Certificate of Coverage; however, the following list may be helpful.

Examples of qualified emergency care may include but are not limited to:

- Penetrating wounds such as knife or gunshot wounds
- Choking
- Burns with blisters over large areas of skin
- Displaced limbs
- Head injuries that cause drowsiness, vomiting, confusion, blurred vision or bleeding from the ears, nose or throat
- Sudden or severe chest pain
- Sudden breathing difficulty
- Sudden vision or hearing loss
- Sudden or persistent mouth or nose bleeding or vomiting of blood
- First-time seizures or recurrent frequent seizures that are unresponsive to current medication
- Suspected or confirmed drug overdose (accidental or intentional)
- Suspected or confirmed breathing difficulty or swallowing of poisonous substances
- Unconsciousness
- Blow to the eye resulting in total or partial loss of vision

An illness or injury that requires medical attention but is not life-threatening is generally not considered a medica emergency, for example: flus, colds, sore throats, strains, earaches, headaches, recurrent arthritis, and minor scrape If you use a non-participating hospital under these circumstances, you may not receive coverage. Regardless, you will be responsible for any amount determined to be in excess of reasonable costs.

What to do in an emergency

If you are unable to reach your doctor and a participating hospital is not available, you should obtain treatment a the nearest facility that is equipped to provide emergency care.

You should then contact the Physician and Medical Services Department (502-580-5050 or 1-800-448-0222) within 24 to 48 hours to ensure that proper payment procedures are initiated. If not, you may be subject to all or part of the emergency room charges.

GHC KY-6488

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Preadmission review and prior authorization

Humana Kentucky Physicians Plan

Humana Health Care Plans uses preadmission review to determine medically necessary and appropriate care. Certain medical procedures require that your physician call for pre-approval from the Plan before hospitalization of members. Other services require that physicians submit written prior authorization. Failure to obtain approval may result in reduced or denied coverage, depending on whether the procedure is medically necessary as determined by us.

The following procedures require prior telephone authorization:

- Adenoid removal
- Carpal Tunnel
- Gall bladder removal
- Colon inspection
- Hysterectomy
- Knee arthroscopy (diagnostic and surgical)
- Back disc surgery
- Lumbar spinal fusion
- Magnetic Imaging studies
- Tonsillectomy
- Eardrum surgery

The following procedures require prior written clinical authorization:

- TMD therapies and surgeries
- All durable medical equipment over $500
- Plastic surgery on the eyelids
- Scar revisions
- Breast reconstruction and/or breast reduction
- Removal of breast or breast tissue (excluding biopsy)
- Any cosmetic procedure or procedure that could be considered cosmetic in nature
- Gastric bypass surgery
- Penile implants
- Penile surgery to increase blood flow
- Reconstruction of structures within the throat
- Speech therapy
- Surgery of the jaw
- Internal reconstruction of the nose
- CPAP and/or BIPAP

This list includes only the most common procedures that require prior authorization. Remember, all inpatient hospitalization also requires telephone preadmission. For a complete listing of all procedures subject to prior authorization, or for more information in general, your physician should call **(800) 523-0023**. This number is printed on your Humana Kentucky Physicians Plan membership card.

Humana® Health Care Plans

GHC KY-2373

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Completing a claim form

When completing a claim form

1. Complete the front side of the form. Complete all applicable entries.
2. Use a separate claim for each family member and for each illness or accident..
3. Your group number is the first six digits of the number marked "Gr." on your I.D. card.
4. Always sign the box marked RELEASE OF INFORMATION/SUBROGATION ACKNOWLEDGMENT.
5. If you wish for payment to go directly to your physician or other provider, you can assign payment by signing the box marked IF PAYMENT IS TO BE SENT DIRECTLY TO PROVIDER.
   If you have already paid the physician or other provider, do not sign the box.

Checking on the status of a claim

1. Call the toll-free claims number shown on your Humana Health Care Plans identification card. All telephone conversations are recorded and the claims representatives will identify themselves by name. Make a note of the time, date and the name of the claims representative for future reference.
2. Have the following information ready:
   - Name of the person who received services
   - Date of service
   - Subscriber's social security number
   - Dollar amount of the claim, if possible.
3. Here are some common causes for delays in settling claims:
   - Incorrect addresses
   - Incorrect subscriber identification numbers
   - Insufficient accident information
   - Coordination of benefits with other insurers
   - Incomplete diagnosis by the physician
   - Non-compliance with preadmission review and prior authorization requirements
   - Bills not itemized
   - Drug names omitted.

Keeping complete records

Remember to keep copies of all bills you receive for medical services, including prescripion drugs.

Note: **When you receive services from a participating hospital, you do not need to file a claim for those services. However, you may receive bills from other providers who are not hospital employees, such as physicians, anesthesiologists, radiologists and pathologists. If you receive separate bills from these providers, you will need to file claims for their services.**

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Provisions of Kentucky Physicians Plan

Humana Health Care Plans

The following provisions are common to each plan:

Coordination of services
Physicians plan services are coordinated with similar services under other group hospital and medical plans. If we are the secondary carrier, our benefit will be the difference between the primary carrier's payment and 100 percent of eligible charges. In no event will use of the coordination of services provision cause the company to pay more than it would have paid, if no other coverage was involved. Your Group Plan/Certificate of Coverage will explain coordination of services in more detail.

Initial copayment credit for takeover groups
Any initial annual copayment amounts accumulated by a member under the employer's current group insurance contract will be credited toward the initial annual copayment amount, such person (employee and/or their eligible dependents) must pay for "Medical services" under the Group Plan.

Dependent coverage
Eligible dependents include the employee's spouse and unmarried children from date of birth to their 19th birthday or to their 25th birthday for full-time students.

Eligibility
Kentucky Physicians Plan is available to members of groups where a formal employer-employee relationship exists.

Pre-authorization requirement
You (plan member) must receive pre-authorization to determine that each surgery, hospital admission and medical procedure/service meets our guidelines of reimbursable, medically necessary treatment. To obtain pre-authorization, you must present your identification card, which shows our toll-free pre-authorization telephone number to the physician. Your physician must call for pre-authorization. If pre-authorization is not obtained, benefits may be reduced by 50 percent for medically necessary services that were provided without authorization. You may be required to pay the entire cost of services you receive if authorization is denied, or if we later determine that the services weren't medically necessary or eligible for coverage.

Skilled nursing facility
The Group Plan provides coverage in a skilled nursing facility each calendar year (requires prior approval by us). Coverage for room and board is based on the facility's most common semi-private rate.

Home health care
The Group Plan provides home health care on a calendar year basis (requires prior approval by us). Coverage is limited to our schedule of reasonable charges.

Maternity services
The Group Plan will provide maternity services for employees and their spouses on the same basis as coverage payable for any other illness. Check your Group Plan/Certificate of Coverage to determine if dependents are eligible for maternity coverage.

Pre-admission testing
Under the Group Plan, pre-admission testing is fully covered at 100 percent. The initial annual copayment amount does not apply.

Pre-existing conditions for new employees entering the Group Plan.
Under the Group Plan, a pre-existing condition is a sickness or injury for which the covered member received treatment (including prescription drugs), consultation or advice during the three-month period immediately prior to the effective date of his or her coverage.

A pre-existing condition will not be covered until the date the covered member completes 12 consecutive months of membership in the Group Plan or the member is free of treatment for a three consecutive month period.

Second surgical opinion
The Group Plan provides full coverage for all second surgical opinions (including additional, not previously completed x-rays and laboratory tests). Second surgical opinions are not subject to any copayments.

Physicians service coverage for non-participating hospitals
If your participating physician admits you (insured) to a non-participating hospital, your coverage for physician services may be reduced, except for a true medical emergency, or if a service is not available at a participating hospital.

Waiting period for membership
At the employer's option, new employees may be subject to a waiting period for the membership in the Group Plan.

The provisions shown here are subject to change without notice.

Limitations and exclusions

Unless specifically stated otherwise, no coverage will be provided for, or on account of the following items:

1. A sickness or injury which is covered under any workers' compensation or similar law.
2. Any service the member would not be legally required to pay for in the absence of this coverage.
3. Sickness or injury for which the member is in any way paid or entitled to payment or care and treatment by or through a government program, other than Medicaid.
4. Education or training; medical services provided by the member's parent, spouse, brother, sister or child.
5. Experimental drugs or substances not approved by the Food and Drug Administration; drugs or substances used for other than Food and Drug Administration approved indications; or drugs labeled: "Caution – limited by federal law to investigational use."
6. Vitamins, birth control pills, unless medically necessary for a medical condition, and non-prescription drugs or medicines.
7. Treatment, services, supplies or surgery that are not medically necessary.
8. Purchase or fitting of hearing aids or advice on their care.
9. Weekend non-emergency hospital admissions.
10. In-vitro fertilization; any medical or surgical treatment of infertility; infertility evaluations; sex change services; or reversal of elective sterilization.
11. Procedures or treatment methods determined by us to be experimental.
12. Cosmetic and reconstructive surgery, unless medically necessary as specified in the Group Plan/ Certificate of Coverage.
13. Any service or supply for dental services, treatment of teeth or periodontium, oral surgery, or any other orthodontic treatment regardless of medical necessity, except as specified in the Group Plan/ Certificate of Coverage.
14. Any service, supply or treatment connected with custodial care.
15. Sickness or injury caused by the member's:
    (a) engaging in an illegal occupation; or
    (b) commission of or an attempt to commit a criminal act.
16. Any surgical procedure to reduce obesity, unless medically necessary.
17. Elective abortion, unless the physician certifies in writing that the pregnancy would endanger the life of the mother.
18. Pregnancy of a child, except for:
    (a) complications arising from it, or
    (b) pregnancies resulting from rape or incest.
19. Vision analysis, testing or orthoptic training or the purchase of eyeglasses or contact lenses.

This is just a partial list of limitations and exclusions and is subject to change without notice. Please check the Group Plan/Certificate of Coverage for a complete listing.

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Supreme Court, U.S.
FILED
SEP 11 2002
CLERK

No. 00-1471

IN THE

Supreme Court of the United States

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., *et al.*,
Petitioners,

v.

JANIE MILLER, COMMISSIONER OF THE KENTUCKY DEPARTMENT OF INSURANCE,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF FOR PETITIONERS

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Attorneys for Petitioners

QUESTION PRESENTED

Are state "Any Willing Provider" statutes preempted by ERISA, or are they saved from preemption because they are laws "which regulate insurance"?

PARTIES

Petitioners are the Kentucky Association of Health Plans, Inc., and Humana Health Plan, Inc., which were both plaintiffs in the district court and appellants in the court of appeals. Other petitioners are Humana Health Plan of Ohio, Inc., which succeeded plaintiff-appellant Choicecare Health Plans, Inc., and Aetna Health Inc. (OH), which succeeded plaintiff-appellant Aetna Health Plans of Ohio, Inc.

HMPK, Inc., and HPLAN, Inc., also plaintiffs-appellants below, have been succeeded by petitioner Humana Health Plan, Inc. Advantage Care, Inc. and FHP of Ohio, Inc., also plaintiffs-appellants below, are no longer parties to this action and are not petitioners in this Court.

Respondent Janie Miller succeeded to the position of Kentucky Commissioner of Insurance after the court of appeals entered judgment in this case, and is accordingly substituted as respondent pursuant to S. Ct. R. 35.3.

CORPORATE DISCLOSURE

Petitioner Kentucky Association of Health Plans, Inc., is a nonprofit corporation with no parent corporation. Aetna Inc., a publicly held company, is the parent corporation of petitioner Aetna Health Inc. (OH). Humana Inc., a publicly held company, is the parent corporation of petitioners Humana Health Plan of Ohio, Inc. and Humana Health Plan, Inc.

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BRIEF FOR PETITIONERS

OPINIONS BELOW

The opinion of the Sixth Circuit is published at 227 F.3d 352 (6th Cir. 2000), and is reprinted in the appendix to the Petition for a Writ of Certiorari ("Pet. App.") at 1a. The opinion of the United States District Court for the Eastern District of Kentucky is unpublished and is reprinted at Pet. App. 64a. The district court's order of final judgment is unpublished and is reprinted at Pet. App. 86a.

JURISDICTION

The opinion and judgment of the court of appeals was entered September 7, 2000. A timely petition for rehearing and suggestion of rehearing en banc was denied by order entered November 20, 2000. Pet. App. 87a. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The relevant provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001, *et seq.*, are reprinted at Pet. App. 88a. The Kentucky "Any Willing Provider" statutes at issue in this case are reprinted at Pet. App. 89a-91a.

STATEMENT OF THE CASE

1. Petitioners are several health maintenance organizations ("HMOs") and a Kentucky-based association of HMOs. As one means of controlling the quality and cost of health care delivery, petitioners and other HMOs have contracted with selectively-chosen doctors, hospitals, and other health care providers to create exclusive "provider networks."[1] These "participating providers" are required by

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[1] It is beyond the scope of this brief to define and distinguish all the different ways that HMOs employ such networks to satisfy their care obligations for their insureds. *See* Weiner & de Lissovoy, *Razing a*

their contracts to provide health care services to the HMOs' subscribers at discounted rates and to comply with other contractual requirements.[2] In exchange for their rate discount, participating providers receive the advantage of access to the HMOs' subscribers and, consequently, increased patient volume over non-network providers who lack such access. *See* Shouldice, Introduction to Managed Care 60 (1991).

The value of network membership (and, accordingly, the amount providers will agree to discount their services) depends on the HMOs' ability to limit the number of providers in the network; the fewer the providers, the greater the patient volume for each provider. *Id.* at 72 ("the panel must be

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Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans, 18 J. Health Politics 75, 75 (1993) ("Today, even seasoned observers are unable to distinguish different health insurance plans from one another."). One point to be clear about, however, is that whereas in the past HMOs might have been understood as providing care less through a "network" of providers and more through a "staff" of paid providers – the so-called "closed" or "staff" HMO – many HMOs now rely on a combination of network-provider options and non-network care options (at higher copayments and deductibles) in the fashion of preferred-provider organizations. *See* Weiner & de Lissovoy, *supra*, at 99; Wagner, *Types of Managed Care Organizations*, *in* Essentials of Managed Health Care 17, 18 (Kongstvedt ed. 2001) ("Today, an observer may be hard pressed to uncover the differences between products that bill themselves as HMOs, PPOs, or managed care overlays to health insurance."). As used in this brief, the term HMO will encompass the older-style "pure" or "closed" or "staff" HMOs – which provide care from providers employed directly by the HMO – as well as the now-more-common arrangements for meeting care obligations through a mixture of networks and non-network provider options. It also bears noting that even HMOs that offer non-network care options have incentives to limit the number of providers that are in their networks, so that they can offer cost incentives to encourage use of their in-network providers. *See, e.g.*, Wagner, *supra*, at 20, 28; Shouldice, Introduction to Managed Care 60 (1991).

[2] Unless otherwise specified, this brief will use the term "contract" to refer to the provider contracts, and the term "policy" will refer to the contractual relationship between the HMO and its insureds, who will also be referred to as "subscribers."

small enough to enable member providers to increase their patient volume significantly"). The ability of the HMO to decide for itself which providers may join its networks is fundamental to the entire enterprise of managing the quality and costs of health care: "[T]he selection of a network of physicians, hospitals, pharmacies, laboratories, and other providers who will furnish services of adequate quality for a specified fee is essential. In selecting a network, MCOs seek to screen out providers whose quality does not meet plan standards and whose practice styles are costly." Rosenblatt, Law & Rosenbaum, Law and the American Health Care System 555 (1997).

Petitioner HMOs make their provider networks available to ERISA-governed employee health benefit plans in two different ways. First, each contracts with ERISA plans to enroll plan beneficiaries as direct subscribers in the HMO. Second, they also make their provider networks available to self-funded employee benefit plans, for which the HMOs provide only administrative services and bear no risk.

2. The laws of the Commonwealth of Kentucky include two provisions that prohibit petitioners from guaranteeing network exclusivity to providers in exchange for rate discounts. These provisions – known generally as "Any Willing Provider" ("AWP") statutes – essentially require petitioners to open their networks to any provider willing to meet the terms of participation. When initially enacted in 1994, the general AWP law was directed at and governed only "health benefit plan(s)." Ky. Rev. Stat. § 304.17A-110(3) (1994). The legislature subsequently recodifed the law and changed the phrase "health benefit plans" to "health insurers," adding a definition of the latter as:

> any insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery

> network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to do transact health insurance business in Kentucky.

Id. § 304.17A-005(23). The law now provides:

> A health insurer shall not discriminate against any provider who is located within the geographical coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer . . . .

Id. § 304.17A-270. In addition to this general AWP law, in 1996 the Legislature enacted another AWP provision specifically addressed to contracts between "health benefit plan[s]" – including HMOs – and chiropractors. *See id.* § 304.17A-171(2). Although still targeted in terms to "health benefit plans," the chiropractic AWP statute does not otherwise differ in substance from the general AWP law.[3]

The purpose and effect of these AWP laws is to require petitioners and other HMOs to throw open their closed provider networks to any provider in the geographic area willing to abide by the terms of their network contracts. Because an HMO's ability to control costs and quality depends in large part on its ability to determine for itself the providers with network access, as discussed above, *see supra* at 2-3, the unavoidable consequence of the laws is to drive up the costs of the health care services managed by HMOs and to affect their ability to regulate efficiently the quality of care offered

[3] The same Act that established the chiropractic AWP law also included other restrictions on petitioners' freedom to contract with chiropractors. *See* Ky. Rev. Stat. § 304.17A-171(1) & (3)-(8). The court below remanded the issue of whether those provisions are preempted by ERISA. Pet. App. 4a n.3.

by network providers.[4] As the Federal Trade Commission opined in commenting on another state's AWP laws:

> Although the law may be intended to assure consumers greater freedom to choose where they obtain services, it appears likely to have the unintended effect of denying consumers the advantages of cost-reducing arrangements and limiting their choices in the provision of health care services.

F.T.C., Opinion Letter to Attorney General of Montana Regarding Any Willing Provider Law, Feb. 4, 1993, *quoted in* Smith & Stewart, *supra* note 4, at 799.

4. Petitioners filed a complaint in April 1997 in the United States District Court for the Eastern District of Kentucky against the Commissioner of the Kentucky Department of Insurance asserting, *inter alia*, that Kentucky's AWP laws are preempted by ERISA. As a general matter, ERISA broadly preempts any state law that "relate[s] to" an ERISA-governed employee benefit plan. 29 U.S.C. § 1144(a). Congress, however, chose to "save" from ERISA's preemptive force any state law "which regulates insurance." *Id.* § 1144(b)(2)(A). In other words, even if a law otherwise "relates to" an ERISA plan, it is not preempted if it is a law "which regulates insurance."

The parties cross-moved for summary judgment on the ERISA preemption count. The district court held the laws protected by the saving clause, and entered an order of final judgment under Rule 54(b) on the ERISA preemption count. Petitioners appealed to the Sixth Circuit.

[4] Studies estimate that AWP laws increase the costs of care managed by HMOs by approximately fifteen percent. Smith & Stewart, *State Regulation of Managed Care*, *in* Essentials of Managed Health Care, *supra* note 1, at 786, 799.

The court of appeals unanimously agreed that Kentucky's AWP laws "relate to" ERISA plans. Pet. App. 7a-19a (majority, per Holschuh, D.J., sitting by designation); *id.* at 39a (Kennedy, J., dissenting). The court split, however, over whether those laws are saved from preemption under ERISA's saving clause as "laws which regulate insurance."

a. Beginning the analysis by considering whether AWP laws "regulate insurance" as a matter of "common sense," *see, e.g.*, *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 367 (1999), the majority focused primarily on the fact that Kentucky's AWP laws apply by their terms to "insurers," Pet. App. 24a-25a. On that basis alone the court determined that the "Kentucky AWP laws are thus specifically directed toward insurers and the insurance industry and are ones that from a 'common sense view' regulate insurance." *Id.* at 25a. Adding further that the AWP laws also "deal directly with the relationship between insurers and insureds under health benefit plans," and "are part of a comprehensive subtitle of Kentucky's insurance code regulating health benefit plans," the court concluded that for those reasons as well the AWP laws are "clearly laws which, in a common sense view of the matter, 'regulate insurance.'" *Id.* at 30a.

In reaching that determination, the panel majority rejected the argument that the AWP laws do not regulate insurance because they apply in fact not just to "insurers" as traditionally understood, but also to employers that pay directly for their employees' health services. Such self-funded plans, the majority held, involve "the business of insurance." *Id.* at 26a. The court brushed aside ERISA's "deemer clause" – which explicitly prohibits states from deeming self-funded plans to be "insurance" for purposes of the saving clause, *see* 29 U.S.C. § 1144(b)(2)(B) – on the unelaborated ground that the statutory distinction between "insurance" and a self-funded employer plan "is not a distinction based upon a concept that employers who choose to be self-

insurers cannot be considered insurers subject to state regulations dealing with insurance." Pet. App. 26a.[5]

The panel majority then looked to the "three factors employed to determine whether the regulation fits within the 'business of insurance' as that phrase is used in the McCarran-Ferguson Act." *Id.* at 20a (quoting *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 367 (1999)). The court found the first – whether the law affects the transfer or spreading of the risk against which the policyholder is insured – to be "certainly a debatable issue," *id.* at 30a, but found it satisfied simply because AWP laws allow insureds to receive covered services from providers for whose services insureds would otherwise pay directly. The panel majority reasoned that AWP laws spread the "cost component" of the policyholder's risk among all insureds, in that the policyholder is not required to shoulder all the cost when seeking care from a provider outside the network. *Id.* at 31a (quoting *Stuart Circle Hosp. Corp. v. Aetna Health Mgmt.*, 995 F.2d 500, 503 (4th Cir. 1993)).

As to the second McCarran-Ferguson factor, the court held that AWP laws govern a practice that is an "integral part of the policy relationship between the insurer and the insured," Pet. App. 35a, even while acknowledging that "it is admittedly true that the AWP laws do not change the substantive terms of the insurance coverage," *id.* at 36a. The court considered the mandatory change "from a closed pool

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[5] The court also held that the AWP statutes do not apply to HMOs that provide solely administrative services to ERISA plans, Pet. App. 26a, 28a n.14, even though both AWP laws specifically include all HMOs within their sweep and neither distinguishes among the services HMOs provide. And despite the fact that even under the court's construction the Kentucky AWP laws apply to HMOs that provide solely administrative services to non-ERISA self-funded plans – and thus bear no risk at all – the court still concluded that the AWP laws are "limited to health care 'insurers.'" *Id.* at 28a.

of providers to an open pool of providers" to be the same as "expanding covered treatment." *Id.*

Finally, bootstrapping its earlier analysis of the laws' application to HMOs and self-funded employer plans under the common-sense prong, the majority concluded that the Kentucky AWP laws are limited to entities within the insurance industry, and thus that the third McCarran-Ferguson factor is satisfied as well. *Id.*

b. Judge Kennedy dissented, rejecting the majority's conclusions at every step of the saving clause analysis. She first concluded that "the Kentucky AWP laws do not meet the common sense test because they are directed at the contracts between benefit plans and third parties, rather than being specifically directed at the insurance industry." Pet. App. 40a. And as applied to HMOs whose only role is administration, Judge Kennedy reasoned, the AWP laws are "not directed at the business of insurance, as no insurance is involved." *Id.* at 43a. In Judge Kennedy's view,

> The common sense conclusion that can be drawn from the AWP statute's coverage of entities clearly operating outside of the business of insurance is that the statute is concerned generally with regulating provider access to networks rather than specifically regulating the business of insurance.

Id. at 44a.

Judge Kennedy found the majority's treatment of the McCarran-Ferguson factors equally uncompelling. Labeling the "cost component" risk-spreading theory relied upon by the majority as "attenuated," *id.* at 55a, Judge Kennedy observed that "[t]he critical issue with respect to the risk-spreading prong . . . is whether or not the law is related to *the risks underwritten by the insurer*," *id.* at 54a (emphasis added). Health insurance policies underwrite only "the risk that [the] insured will need medical treatment for a condition

covered under the policy," *id.* at 56a, and under Kentucky's AWP laws, Judge Kennedy explained, "[t]here is no shifting of [that] risk," *id.*; *see id.* at 54a (AWP laws merely "dictat[e] how [insurers] structure their provider networks, irrespective of the risks they underwrite").

As to whether the AWP laws are integral to the insured-insurer relationship, Judge Kennedy considered the matter quite clear:

> Kentucky's AWP provisions leave the contract terms between the insurer and insured[] unaltered. The relationships directly affected by the law are those existing between insurers and third parties (*i.e.*, medical providers). . . . [T]he medical risks covered by the policy remain the same. Thus, even if an insured's preferred provider decides to join the insured's network, and complies with its terms in doing so, the medical coverage that the insurer has contracted to underwrite remains unchanged. . . . Kentucky's AWP laws do not force the insurer to offer a benefit to insureds that was not available before the law.

Id. at 59a. Finally, incorporating her discussion of the common-sense prong, Judge Kennedy concluded that the AWP laws fail the third McCarran-Ferguson factor because they "extend[] to include entities in no way involved in underwriting risks." *Id.* at 59a-60a.

SUMMARY OF ARGUMENT

A. In *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), this Court held that an insurer's contracts with pharmacies to provide drugs at a fixed low cost to insureds was not part of the insurer's "business of insurance" for purposes of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011, *et seq*. In so holding, the Court also devised the three-part test now employed to help determine whether state laws are saved from preemption under ERISA as laws

that "regulate insurance." The pharmacy contracts, the Court held, did not involve the spreading of any risk between insurer and insured, were not integral to any aspect of the contract between insurer and insured, and implicated entities outside the insurance industry – the pharmacies involved. Exactly the same is true of the HMO provider contracts at issue in this case, which are factually and legally indistinguishable from the pharmacy contracts at issue in *Royal Drug*. HMOs rely on provider contracts to control the costs of providing the care promised in the HMO policies, just as the insurer in *Royal Drug* relied on its provider contracts to control the costs of providing the drugs promised in its drug benefit policy.

The two grounds suggested for distinguishing HMO provider contracts from the *Royal Drug* provider contracts are without merit. The first is that HMOs, unlike the insurer in *Royal Drug*, typically limit the number of providers who may enter into such contracts. That supposed distinction has nothing to do with the question resolved in *Royal Drug* and at issue again here, which is whether the practice of entering into *any* such contracts is an "insurance" practice. The second is that HMO provider contracts affect the HMO policy relationship more directly because HMOs spread a different kind of risk than did the traditional insurance policy at issue in *Royal Drug*. That argument, too, is incorrect: HMOs, just like traditional insurance plans, insure against the risk of financial loss arising from the need to obtain care. And HMOs use provider contracts to control their own costs of underwriting such losses, in just the same way the insurer in *Royal Drug* used pharmacy provider contracts to control its underwriting costs. *Royal Drug*'s conclusion that such cost control measures, while sound business practices, are not *insurance* practices, governs here.

B. Nothing in the ERISA saving clause precedents that have followed *Royal Drug* changes the analysis or result of

the case in respect to whether an insurer's provider contracts are "insurance." The critical question under the "common sense" test is whether the law regulates the "insurance practices" of "insurers." *Rush Prudential HMO, Inc. v. Moran*, 122 S. Ct. 2151, 2159 (2002). AWP laws do not regulate insurance as a matter of common sense because they are not targeted at insurance practices, nor even exclusively at insurers. By barring HMOs from entering limited network contracts with providers, AWP laws control the conduct of the providers who would seek to enter into such agreements (and thereby obtain a financial advantage over competitors) as much as they regulate the HMOs themselves. They are also irrelevant to the "insurance" that HMOs provide, *viz.*, protection against the risk of loss arising from the need to pay for medical care. An HMO's duty to protect against such loss by providing care is wholly unaffected by its decision about whom to contract with to provide such care. The laws this Court has previously found to be laws that regulate insurance as a matter of common sense all regulated the terms of the insurance policy itself. AWP laws, by contrast, regulate non-insurance contracts between non-insurers and insurers, and thus are not laws that regulate insurance from a common-sense view of the matter.

To "test" the result of the common-sense inquiry, the Court applies the same factors *Royal Drug* applied in concluding that an insurer's provider contracts are not an insurance practice. Application of those factors naturally leads to the same result here. Provider contracts are no more about risk spreading – the essential element of insurance, according to *Royal Drug* – today than they were two decades ago. Nor do AWP laws change anything "integral" to the HMO policy relationship. AWP laws require that an HMO allow any provider willing to accept a network contract's terms to join the network, but they in no way ensure that the subscriber's provider of choice will join the network. To the contrary, providers must be both able and willing to join the network,

and there are many reasons providers would not choose to join a given network. And AWP laws obviously regulate entities outside the insurance industry – the providers themselves. The provider contracts targeted by the laws are not limited to "insurers," and they do not involve "an insurance practice."

Finally, there is no merit to any suggestion that the *Royal Drug* factors are not relevant to, or operate more narrowly in, the ERISA saving clause context. This Court has repeatedly looked to these factors in saving clause cases, including just last Term in *Rush Prudential*. The *Royal Drug* analysis of "insurance" is highly relevant in any ERISA saving clause case; in this one, it is conclusive.

ARGUMENT

BECAUSE AN HMO'S CONTRACTS WITH THIRD-PARTY PROVIDERS ARE NOT "INSURANCE," THE AWP LAWS THAT REGULATE THOSE CONTRACTS ARE NOT SAVED FROM PREEMPTION AS LAWS THAT "REGULATE INSURANCE"

ERISA broadly preempts any state law that "relates to" employee benefit plans, 29 U.S.C. § 1144(a), in the sense that the law has either a "connection with" or a "reference to" such plans, *Cal. Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 324, 329 (1997). There is no serious dispute that the Kentucky AWP laws at issue here "relate to" employee benefit plans under these twin standards, as the court below unanimously determined. Pet. App. 10a-19a. AWP laws "bear[] indirectly but substantially on all insured benefits plans," *Rush Prudential*, 122 S. Ct. at 2159 (quoting *Met. Life v. Massachusetts*, 471 U.S. 724, 739 (1985)), by precluding them from purchasing medical coverage from HMOs with limited provider networks. In this respect they affect both plan administration and plan benefits, and thus have a "connection with" ERISA plans. Pet. App. 19a; *see* U.S. Pet. Br. 7-8 (agreeing that AWP laws

have "connection with" ERISA plans). In addition, the Kentucky Act's explicit "exclusion of self-insured ERISA plans from its coverage" satisfies the "refers to" prong of the preemption analysis, Pet. App. 15a, because the exclusion singles out ERISA plans for differential treatment, *id.* at 13a (citing *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 830 (1988)).

Though AWP laws therefore would normally be preempted on these grounds, ERISA "saves" from such preemption those laws that specifically "regulate[] insurance." To fall within the compass of the saving clause, the law must do more than just regulate *insurers*; it is only when "insurers are regulated *with respect to their insurance practices*" that "the state law survives ERISA." *Rush Prudential*, 122 S. Ct. at 2159 (emphasis added). Accordingly, the question in any insurance saving clause case is whether the practice the state law regulates is an "insurance practice," or is some other practice an insurer (or other entity) may choose to pursue.

To answer that question, this Court takes a "commonsense view of the matter," *id.* (quoting *Metropolitan Life*, 471 U.S. at 740), but confirms that view by examining three principles enunciated in cases interpreting the closely analogous McCarran-Ferguson Act provision protecting state laws that regulate the "business of insurance": whether the practice being regulated is one that affects the spreading of risk across all insureds; whether the practice is integral to the policy relationship between the insurer and insured; and whether the practice involves entities outside the insurance industry. *See, e.g., id.*; *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48-49 (1987).

The first McCarran-Ferguson case to identify the factors now employed in the saving clause inquiry was *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). *See Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982) ("*Royal Drug* identified three criteria rele-

vant in determining whether a particular practice is part of the 'business of insurance'"). In that case, the Court applied the three factors to determine that a contract between a health insurer and a third party to provide pharmacy services to insureds is not "insurance." 440 U.S. at 212.

The question in this case is in substance identical to the question in *Royal Drug*: whether an HMO's contract with a third party to provide services to ERISA plan beneficiaries is an "insurance" practice. The Kentucky laws at issue here purport to regulate such third-party contracts by barring HMOs from limiting the number of providers with whom the HMOs will contract. If the practice of entering such contracts is an "insurance" practice, then the state laws regulating that practice are laws that "regulate insurance," and they are saved from preemption by ERISA. But *Royal Drug* already held that the practice of entering such contracts is *not* an "insurance" practice for purposes of the McCarran-Ferguson Act. And inasmuch as that very holding laid the foundation for the ERISA saving clause analysis, the result must be the same in the ERISA context as well.

A. This Court Already Held In *Royal Drug* That Third-Party Provider Agreements Identical To Those Regulated By Kentucky's AWP Laws Are Not The "Business of Insurance"

The question in this case – whether HMO contracts with third-party service providers are "insurance" – was answered by this Court in the negative on indistinguishable facts in *Royal Drug*.

1. The insurance company in *Royal Drug* provided a benefit in the form of prescription drugs. In exchange for their premium payments, insureds were promised that they could obtain prescription drugs for no more than $2. 440 U.S. at 212, 216 n.14. To satisfy the obligation to its insureds, the insurance company offered to enter into contracts with pharmacies, pursuant to which each pharmacy would

agree to provide prescription drugs to the insurance company's insured for $2, and the insurance company would pay the pharmacy directly for the cost of the drug. *Id.* at 209. Thus, "only pharmacies that [could] afford to distribute prescription drugs for less than this $2 markup [could] profitably participate in the plan." *Id.* Several large pharmacy chains accepted the contracts and joined the network.

Eighteen independent pharmacies filed an action challenging the third-party pharmacy provider contracts under the Sherman Act as a retail drug price-fixing conspiracy and as a concerted refusal to deal. The insurance company defended on the ground that its provider contracts were exempt from the Sherman Act because they constituted the "business of insurance" under § 2(b) of the McCarran-Ferguson Act. *Id.* at 208.

This Court rejected the insurance company's argument, identifying three reasons for concluding that an insurer's third-party provider contracts are *not* "the business of insurance." Those reasons became identified in later cases as the "three criteria relevant in determining whether a particular practice is part of the 'business of insurance.'" *Pireno*, 458 U.S. at 129.

a. The first reason third-party provider contracts are not insurance, the Court explained, is that they lack an "indispensable characteristic of insurance": the "underwriting or spreading of risk." *Royal Drug*, 440 U.S. at 212. Though later cases have indicated that none of the three factors ultimately discussed in *Royal Drug* is "necessarily determinative in itself," *Pireno*, 458 U.S. at 129; *see, e.g.*, *Rush Prudential*, 122 S. Ct. at 2163 (declining to consider risk-spreading factor); *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 373 (1999) (same), at least as applied to an insurer's third-party contracts, the risk-spreading factor is conclusive. Citing basic insurance law authorities, the Court in *Royal Drug* explained:

> The primary elements of an insurance contract are the spreading and underwriting of a policyholder's risk. "It is characteristic of insurance that a number of risks are accepted, some of which involve losses, and that such losses are spread over all the risks so as to enable the insurer to accept each risk at a slight fraction of the possibility of liability upon it." 1 G. Couch, Cyclopedia of Insurance Law § 1:3 (2d ed. 1959). See also R. Keeton, Insurance Law § 1:2(a) (1971) ("Insurance is an arrangement for transferring and distributing risk"); 1 G. Richards, The Law of Insurance § 2 (W. Fredman 5th ed. 1952).

440 U.S. at 211. The Court also drew upon its own precedents for the significance of risk-spreading in identifying an "insurance practice." The Court observed that *SEC v. Variable Annuity Life Insurance Co.*, 359 U.S. 65 (1959), had held that sales of annuity contracts by life insurance companies were not "insurance" – even though such sales "were regulated as [insurance] under state law and involved actuarial prognostications of mortality" – because "they placed all the investment risk on the annuitant and none on the company." 440 U.S. at 212. Accordingly, the Court explained, the annuities sold by the life insurance companies in *Variable Annuity Life* "involved 'no true underwriting of risks, *the one earmark of insurance* as it has been commonly conceived of in popular understanding and usage.'" *Id.* (quoting 359 U.S. at 73) (emphasis added). The Court also quoted another of its precedents noting that the "effect of insurance – indeed it has been said to be its fundamental object – is to distribute the loss over as wide an area as possible." *Id.* at 212-13 (quoting *German Alliance Ins. Co. v. Lewis*, 233 U.S. 389, 412 (1914)). The Court concluded from these authorities and precedents that the existence of risk-underwriting is "a critical determinant in identifying insurance." *Id.* at 213.

The Court then explained why an insurance company's contracts with third-party providers do not spread or underwrite risk and therefore are not insurance. The insurance company in *Royal Drug* argued that third-party provider contracts do underwrite risk because they assure that the insurer will indemnify the insured against the financial loss arising from the need to purchase drugs. That argument was incorrect, the Court stated, because it "confused" the insurance company's obligations to its policyholders, which were to make prescription drugs available for a $2 copayment, with the insurance company's provider contracts, which "serve[d] only to minimize the costs [the insurer] incur[red] in fulfilling its underwriting obligations." *Id.* at 213; *see id.* at 216 n.14 ("[T]he benefit Blue Shield provides its policyholders is the assurance that they can obtain drugs in return for a direct maximum payment of $2 for each prescription. The Pharmacy Agreements are separate contractual arrangements between Blue Shield and certain pharmacists fixing the cost Blue Shield will pay for the drugs."). Third-party provider agreements "thus do not involve any underwriting or spreading of risk, but are merely arrangements for the purchase of goods and services by [the insurer]," *id.* at 214 – arrangements that simply "reduce the costs to the [insurers] of meeting their underwriting obligations to their policyholders," *id.* at 222. Noting the "important distinction" between risk *underwriting* and risk *reduction*, the Court explained that even though contracting with providers to control the total amount of its liability for benefit obligations may reduce the insurer's own risk of monetary loss, because provider contracts do not spread the risk more widely among insureds, "there is no underwriting of risk." *Id.* at 214 n.12. In sum, third-party provider contracts merely

> enable [the insurer] to minimize costs and maximize profits. Such cost-saving arrangements may well be sound business practice, and may well inure ultimately to the benefit of policyholders in the form of

> lower premiums, but they are not the "business of insurance."

Id. at 214.[6]

b. Having determined that an insurer's third-party provider contracts are not insurance simply because they do not involve risk spreading, the Court went on to confirm that conclusion by considering "[a]nother commonly understood aspect of the business of insurance": "the contract between the insurer and the insured." *Id.* at 215. The "core of the 'business of insurance,'" the Court explained, is the "relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation and enforcement." *Id.* at 215-16 (quoting *SEC v. Nat'l Sec., Inc.*, 393 U.S. 453, 460 (1969)). Not only are third-party provider contracts "not between insurer and insured," the Court observed, but they cannot be said to "so closely affect the reliability, interpretation, and enforcement of the insurance contract" as to place them in the class of "insurance" practices. *Id.* at 216 (internal quotation marks omitted). This argument, the Court held, "proves too much." *Id.*

> At the most, the petitioners have demonstrated that the [provider contracts] result in cost savings to [insurers] which may be reflected in lower premiums if the cost savings are passed on to policyholders. But, in that sense, every business decision made by an insurance company has some impact on its reliability, its ratemaking, and its status as a reliable insurer. . . .

[6] Further confirming the distinction between risk underwriting through spreading and risk reduction through cost control, the Court quoted from a House Report that accompanied the drafting of McCarran-Ferguson: "'The theory of insurance is the distribution of risk according to hazard, experience, and the laws of averages. These factors are not within the control of insuring companies in the sense that the producer or manufacturer may control cost factors.'" 440 U.S. at 221 (quoting H.R. Rep. No. 78-873, at 8-9 (1943)).

> If [the Act] were interpreted in the broad sense urged by the petitioners, almost every business decision of an insurance company could be included in the "business of insurance."

Id. at 216-17; *see id.* at 232 ("If agreements between an insurer and retail pharmacists are the 'business of insurance' because they reduce the insurer's costs, then so are all other agreements insurers may make to keep their costs under control – whether with automobile body repair shops or landlords."). "Such a result," the Court concluded, "would be plainly contrary to the statutory language, which exempts the 'business of insurance' and not 'the business of insurance companies.'" *Id.* at 217. What properly matters, the Court explained, is whether the insurer satisfies its obligation under the insurance contract: "So long as th[e] promise [to provide drugs for $2 maximum] is kept, policyholders are basically unconcerned with arrangements made between [the insurer] and participating pharmacies." *Id.* at 214.[7]

c. A final reason provider agreements are not the "business of insurance," the Court held, is that they "involve parties wholly outside the insurance industry." *Id.* at 231. Specifically addressing a case involving the provider contracts of a group health organization that would now be called an

[7] This was so, the Court held, even though the pharmacy provider contracts were "indirectly referred to in the insurance policies," because the only actual obligation of the insurer was to provide the $2 drug benefit, and the provider contracts were merely the insurer's way of satisfying that obligation. 440 U.S. at 216 n.14. And, the Court added, even if "some type of provider agreement is necessary for a service benefit plan to exist," to say that the agreement is therefore "insurance" still proves too much: "Assume, for example, that an indemnity insurer must have a line of credit or other commercial arrangement with a bank in order to pay off monetary claims. Despite the fact that the line of credit is 'necessary' for the insurer to fulfill its obligations, it is nevertheless not the 'business of insurance.'" *Id.* at 214 n.9.

HMO,[8] the Court held that, while it may have been debatable whether such organizations are themselves the "business of insurance," it is "next to impossible to assume that Congress could have thought that agreements (even by insurance companies) which provide for the purchase of goods and services from third parties at a set price are within the meaning of that phrase." *Id.* at 230. Accordingly, the fact that provider contracts "involve the mass purchase of goods and services from outside the insurance industry" provided additional confirmation that such contracts are not themselves the "business of insurance." *Id.* at 224.

2. The HMO provider contracts regulated by Kentucky's AWP laws are indistinguishable from the pharmacy provider agreements at issue in *Royal Drug*. Just like the insurer in *Royal Drug*, petitioners promise pharmacy, health, hospital, and other medical services to their members, either for no cost or markedly reduced costs, in exchange for advance premium payments. Just like the insurer in *Royal Drug*, petitioners arrange to satisfy that obligation by entering into contracts with pharmacies, doctors and hospitals, pursuant to which petitioners promise specified payments in exchange for the provision of services to petitioners' members. Just like the insurer in *Royal Drug*, petitioners' HMO policies do not promise the provision of care by any particular doctor, only that care will be provided at the cost (if any) to the insured specified in the policy. If the pharmacy provider contracts at issue in *Royal Drug* were not the "business of insurance," then neither are the provider contracts here.

Two related arguments have been advanced for distinguishing the *Royal Drug* provider agreements on their facts from petitioners' provider agreements. Both arguments are meritless.

a. The principal ground identified by the court below for distinguishing the agreements is that HMO provider networks are intentionally limited, whereas the insurer in *Royal Drug* "did not restrict the number of providers in question." Pet. App. 32a. Thus, the majority below reasoned, the "benefit conferred on the insureds by the Kentucky AWP statutes – removal of restrictions on the number of providers – was already present in *Royal Drug*." *Id.*

That "distinction" wholly misses the point: if what insurers were doing in *Royal Drug* was *not* the "business of insurance," a law requiring insurers to do exactly what the insurers in *Royal Drug* were doing is not a law regulating the "business of insurance." Indeed, *Royal Drug* itself explicitly uses the example of a limited network to prove why the open network in that case was not "insurance." As the Court explained, the provider contracts offered to all licensed pharmacies were "legally indistinguishable" from the situation in which

> an insurance company enter[s] into a contract with a large retail drug chain whereby its policyholders could obtain drugs under the policies only from stores operated by this chain. The justification for such an

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[8] The case is *Jordan v. Group Health Assoc.*, 107 F.2d 239 (D.C. Cir. 1939). According to the *Royal Drug* Court's description of the entity in that case:

> Group Health was organized as a nonprofit corporation to provide various medical services and supplies to members who paid a fixed annual premium. To implement the plan, Group Health contracted with physicians, hospitals, and others, to provide medical services. These groups were compensated exclusively by Group Health. By contracting with the various medical groups directly, Group Health was able to obtain services at a lower cost than if each member contracted separately. The plan, therefore, was somewhat similar to the Pharmacy Agreements in this case.

440 U.S. at 227-28. While staff HMOs like Group Health are "somewhat similar" to the Pharmacy Agreements in *Royal Drug*, the provider network contracts frequently employed by HMOs today, *see supra* note 1, are indistinguishable from them.

> agreement would be administrative and bulk-purchase savings resulting from obtaining all of the company's drug needs from a single dealer. Even though these cost savings might ultimately be reflected in lower premiums to policyholders, would such a contract be the "business of insurance"?

440 U.S. at 215. If a contract limited to a single pharmacy chain to obtain a price advantage by assuring the chain increased volume is not the "business of insurance," neither is a set of contracts limited to certain providers in order to obtain a price advantage by assuring the providers increased volume.

In short, contrary to the view of the court below, the question *Royal Drug* asks is simply whether contracts between an insurer and a network of third-party providers – whether limited or not – are the business of insurance. *Royal Drug* explicitly answers that question no, and that answer must govern here.

b. The other ground offered for distinguishing HMO provider contracts with those of the insurer in *Royal Drug* is that HMO provider contracts affect the insurer-insured relationship more directly, including the specific risk the HMO subscriber is insuring against. As the Fourth Circuit has explained the argument, although "facially" an AWP law "only directly affects providers, it indirectly affects the insured's choice of provider and the consequent cost to the insured if he or she deems an excluded provider to be better qualified for treatment of a specific illness or accident. In this way it affects the risk that an insured must bear." *Stuart Circle Hosp. Corp. v. Aetna Health Mgmt.*, 995 F.2d 500, 504 (4th Cir. 1993). Elaborating its analysis of the relevant "risk," the court explained that by limiting the number of providers available to provide promised care, an HMO compels the insured to bear "all or part of the cost of the doctor or hospi-

tal *that is not preferred by the insurer*." *Id.* at 503 (emphasis added).

That analysis essentially suggests that HMO provider contracts can be distinguished from the *Royal Drug* pharmacy provider contracts because HMO *policies* insure against a different kind of risk – specifically, the risk of needing to pay for care from a provider preferred by the insured, as opposed to simply the risk of needing to pay for care at all. That is a fundamental misapprehension of HMO policies, which do not in fact differ in kind from the drug benefit policy at issue in *Royal Drug*.

The fact is that HMOs, like traditional indemnity health insurers, simply insure against the risk that a policyholder will get sick or hurt and need "specified health care." *Rush Prudential*, 122 S. Ct. at 2160 (quoting *Pegram v. Herdrich*, 530 U.S. 211, 218 (2000)). The "risk" inherent in all forms of insurance concerns loss, *see* Mehr & Cammack, Principles of Insurance 18 (7th ed. 1980), and the loss at issue in this context is the imposition of a financial obligation arising out of injury or illness, *see* Weiner & de Lissovoy, *supra* note 1, at 81 ("Health insurance plans exist mainly because of the consumer's desire to share the financial risk arising from expenses associated with treating (or preventing) an illness or injury."); Note, *Group Health Plans: Some Legal and Economic Aspects*, 53 Yale L.J. 162, 172 (1943) ("the underlying risk-distribution function of" HMO-style plans is "to insure the potential patient against the unpredictable occurrence of sickness"). Whereas traditional indemnity insurers cover a financial obligation arising from needed medical care by providing cash payment for the care, HMOs cover that obligation simply by providing the care itself. *Rush Prudential*, 122 S. Ct. at 2160. Thus, contrary to the *Stuart Circle* court's conception of HMOs, the "risk" HMOs insure against is not the loss arising out of a desire to pay one provider rather than another for particular care. No health insurance

policy deals with that kind of risk. What they underwrite is the loss arising from the need to pay for care at all. *See* Note, *The Legal Problems of Group Health*, 52 Harv. L. Rev. 809, 814-15 (1939) ("it seems clear that, in the case of the cooperative health associations, indemnification against medical cost rather than the unique services of the physicians is the principal object of the relationship").

The terms of HMO policies themselves bear this out. *Cf. Pireno*, 458 U.S. at 131 (a "fundamental principle of insurance" is that "the insurance policy defines the scope of risk assumed by the insurer from the insured"). The *Stuart Circle* court itself correctly describes "the 'policyholder's risk'" under typical HMO policies as including "the types of illness and injury that the insurance contract covers, [the] provision for treatment, and the cost of the treatment." 995 F.2d at 503. Nowhere do any of those standard "risk" terms include coverage for loss arising out of the unavailability of a *particular provider*. Petitioners' HMO policies are to the same effect: as all three judges below recognized, the HMO policies in this case do *not* promise care *from a particular provider*, any more than indemnity insurers promise to pay cash from a particular bank. *See* Pet. App. 36a (maj. op.) ("it is admittedly true that the AWP laws do not change the substantive terms of the insurance coverage"); *id.* at 56a (dissent) ("The insurance policies and the contingencies it underwrites, *i.e.*, the risk that the insured will need medical treatment for a condition covered under the policy, remain the same, regardless of Kentucky's AWP law."); J.A. 65a-76a (covered medical services of exemplary petitioner HMO policy). Petitioners' HMO policies underwrite the insured's risk of financial loss from medical expenses simply by promising to provide the needed care – just like the insurance policy in *Royal Drug* underwrote the risk of financial loss from prescription drug expenses by promising that the insured would receive needed drugs at a fixed price.

To be sure, as a practical matter provider contracts are necessary for an HMO to fulfill its policy obligations, but the "HMO is still bound to provide medical care to its members . . . regardless of the ability of physicians or third-party providers to honor their contracts with the HMO." *Rush Prudential*, 122 S. Ct. at 2162; *see supra* at 18-19 (discussing Court's rejection of same argument in *Royal Drug*). That is, the only obligation legally relevant to the HMO policy relationship is the obligation to provide care; the particular nature of the arrangements with providers the HMO makes – whether they are on a limited basis or not – are immaterial to that obligation. In the same vein, an insured may well have an interest in which doctors are available to him, but that does not bear on the risk of financial loss underwritten by the HMO, any more than the desire of an insured in *Royal Drug* to buy $2 prescription drugs from the local apothecary affected the loss underwritten there. *See* Pet. App. 54a (Kennedy, J., dissenting) ("This is not to say that at least some participants would not be disappointed by the fact that their pharmacy of choice might not have been included, if for example it was not large enough to provide prescriptions for only a two-dollar mark-up. However, the *financial* risks that Blue Shield agreed to cover remained unchanged . . . .").[9]

The underwriting of the potential financial losses imposed by medical expenses is the entirety of the "insurance" aspect of the business of HMOs. The provider contracts an HMO enters into to control its own costs of covering those expenses simply do not relate to *any* question of what risks of loss are assumed or how widely they are spread.[10] Such

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[9] AWP laws, in any event, have no direct impact on the subscriber's interest in his or her choice of provider; as discussed below, *infra* at 33-34, such laws in no way mean that a subscriber's preferred provider will become a member of the network.

[10] *See Express Scripts, Inc. v. Wenzel*, 102 F. Supp. 2d 1135, 1153 (W.D. Mo. 2000) ("Any Willing Provider statutes . . . do not require insurance companies to cover different kinds of services. Instead, they only

contracts may well be good business for HMOs, but they are not the business of *insurance*.

B. The Holding And Analysis Of *Royal Drug* Fully Apply In The ERISA Saving Clause Context

Royal Drug, of course, arose under the McCarran-Ferguson Act and not the ERISA saving clause. If *Royal Drug*'s conclusion that an insurer's third-party contracts are not part of the "insurance" aspect of their business does not answer the ERISA saving clause question whether laws regulating such contracts are laws regulating "insurance," it can only be because there is something about the analysis of "insurance" in this Court's saving clause precedents that compels a different conclusion. But if there is any substantive difference at all between the two inquiries, it does not affect analysis of an insurer's third-party provider contracts. That is, such contracts are not "insurance" under this Court's saving clause precedents for essentially the same reasons they are not the "business of insurance" under the McCarran-Ferguson factors discussed in *Royal Drug*.

As previously noted, this Court's very first ERISA saving clause precedent adverted explicitly to the three *Royal Drug* criteria to determine whether the law at issue was one that "regulates insurance." *See Metropolitan Life*, 471 U.S. at 743. But that case also initiated the tradition of beginning the saving clause inquiry with the question whether the law regulates insurance "from a common-sense view of the matter." *See UNUM*, 526 U.S. at 367 (citing *Metropolitan Life* for "common-sense" test). Each of the Court's saving clause

require insurance companies to allow a greater number of providers to offer these services to insureds. . . . However, even without the statute, the insured would be able to see a general practitioner in the insurance company's network. Thus, in either case, the risk that the insured will need to see a general practitioner is borne by the insurance company. This is why Any Willing Provider statutes do not spread risk."), *aff'd*, 262 F.3d 829 (8th Cir. 2001).

precedents since *Metropolitan Life* has begun the saving clause analysis with this common-sense inquiry, then proceeded to "test the results" of that inquiry by reference to the more specific *Royal Drug* factors for identifying insurance laws under the McCarran-Ferguson Act. *Rush Prudential*, 122 S. Ct. at 2159.[11] It is not clear how much, if at all, the common-sense inquiry differs in substance from the three-factor *Royal Drug* analysis; what is clear is that the "combined" test "parses the 'who' and the 'what': when insurers are regulated with respect to their insurance practices, the state law survives ERISA." *Id.*

1. Kentucky's AWP laws do not regulate insurance as a matter of common sense: they regulate neither insurers exclusively, nor the insurance practices of insurers. Instead the laws regulate insurers *and providers*, by barring the latter from entering into limited network contracts with the former. And that third-party contractual relationship is not – as *Royal Drug* instructs – an *insurance* practice.

The "common-sense enquiry focuses on 'primary elements of an insurance contract[, which] are the spreading and underwriting of a policyholder's risk.'" *Rush Prudential*, 122 S. Ct. at 2159 (quoting *Royal Drug*, 440 U.S. at 211). In this respect the common-sense inquiry reflects the very heart of the *Royal Drug* analysis, and thus could hardly

[11] The court below suggested that if the common-sense test is satisfied, it is not necessary for a law to satisfy *any* of the *Royal Drug* factors. Pet. App. 38a. That cannot be correct: if the specific purpose of the factors is, as *Rush Prudential* states, to "test" and "confirm" the results of the common-sense inquiry, the failure to satisfy any of the factors means the result of the common-sense inquiry *was wrong* – the practice the law regulates has turned out on closer, more rigorous inspection not to be an insurance practice. In this sense the *Royal Drug* factors are not necessarily always of "secondary importance", Pet. App. 22a; they are factors that may provide needed specificity and guidance in hard or close cases, under which circumstances they may be more important than the common-sense test.

be expected to lead to a different result with respect to third-party provider contracts. As we have seen, HMO provider contracts do not implicate the primary elements of an insurance contract – the spreading and underwriting of risk – any more than the provider contracts in *Royal Drug* did. Put differently, the contracts regulated by the AWP laws are in no way insurance contracts. They are contracts between insurers and non-insurer third-party providers – pharmacies, doctors, hospitals, and so on. The laws govern the conduct of these non-insurers just as much as they do HMOs: providers are barred from entering into limited network contracts with HMOs to provide care to their insureds. The laws thus deprive providers of the increased patient volume (and hence income) that such networks offer. *See supra* at 2-3. The laws are written as if they regulate essentially only HMOs and other insurers, to be sure, but they plainly govern the contracts and conduct of non-insurer providers as well.[12]

AWP laws thus do not regulate insurance as a matter of common sense. The laws that this Court previously has found to "regulate insurance" under the common-sense inquiry confirm the point. *UNUM*, for example, involved a California law barring insurers from denying claims on the basis of failure to give notice of the claim unless the insurer could show actual prejudice. The law "regulates insurance"

[12] The court below concluded that Kentucky's AWP laws satisfy the common-sense inquiry for little reason other than that they appear in the state insurance code. Pet. App. 24a-25a. This is surely incorrect: this Court has more than once held that certain practices are not the "business of insurance," "notwithstanding their classification as such for the purpose of state regulation." *Rush Prudential*, 122 S. Ct. at 2162 n.5; *see Royal Drug*, 440 U.S. at 230 n.38 (citing cases "recogniz[ing] that state regulation of a practice of an insurance company does not mean that the practice is the 'business of insurance'"). Thus the fact that the AWP laws appear in the state insurance code may be "relevant to" the common-sense inquiry, *Rush Prudential*, 122 S. Ct. at 2162 n.5, but it cannot be dispositive in and of itself.

as a matter of common sense, the Court held, because it "controls the terms of the insurance relationship" and is "applicable only to insurance contracts." 526 U.S. at 368; *id.* at 373 ("notice-prejudice is a rule of law governing the insurance relationship distinctively"). In this regard *UNUM* closely follows the seminal ERISA saving clause precedent, *Metropolitan Life*, which held that a law that regulates the specific terms of an insurance policy is, "[t]o state the obvious," a law that regulates insurance as a matter of common sense. 471 U.S. at 740. *UNUM* also presaged the Court's most recent saving clause case, *Rush Prudential*, which held that a state law affecting HMO contract terms by granting policyholders the right to an independent medical review of an HMO benefit determination is a law that regulates insurance. *See* 122 S. Ct. at 2164 (law granted "a legal right to the insured, enforceable against the HMO, to obtain an authoritative determination of the HMO's medical obligations"); *see also FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990) (state anti-subrogation law falls within saving clause because it "directly controls the terms of insurance contracts by invalidating any subrogation provisions that they contain").

All these precedents reflect the common-sense conclusion that a law that specifically regulates the terms of insurance policies is a law that regulates insurance. It would be almost absurd to conclude otherwise. *See United States Department of Treasury v. Fabe*, 508 U.S. 491, 504 (1993) ("There can be no doubt that the actual performance of an insurance contract falls within the 'business of insurance,' as we understood that phrase in *Pireno* and *Royal Drug*. To hold otherwise would be mere formalism."). But AWP laws concededly do *not* alter, regulate or affect the terms of insurance policies. Pet. App. 36a (maj. op.); *see supra* at 23-25 (discussing HMO policies). What they regulate are the contracts with non-insurers HMOs pursue to satisfy the obligations of their policies. They thus do not fit within this

Court's common-sense analysis of laws that regulate insurance.

To be clear: we do not argue that AWP laws do not regulate insurance on the ground that HMOs do not act as insurers. That argument has been foreclosed by *Rush Prudential*. But *Rush Prudential* makes equally clear that unless the law in issue regulates specifically the "insurance practices" of "insurers," it is not a law that regulates insurance. 122 S. Ct. at 2159.[13] AWP laws fail both sides of that equation: they regulate an HMO practice – the designation of

[13] It is easy to mistake the common-sense inquiry for an inquiry solely into the question of "who" is being regulated. The Court's description in *UNUM* of the common-sense inquiry as asking whether the regulation "homes in on the insurance industry," 526 U.S at 368, and in *Rush Prudential* as whether the regulation is "'directed toward' the insurance industry," 122 S. Ct. at 2163, might suggest that so long as the law regulates "insurers," it is a law that "regulates insurance." *Rush Prudential* squarely rejects any such understanding: what matters, *Rush Prudential* makes clear, is whether the law regulates the "insurance practices" of "insurers," "focus[ing] on the 'primary elements of an insurance contract[, which] are the spreading and underwriting of a policyholder's risk.'" *Id.* at 2159 (quoting *Royal Drug*, 440 U.S. at 211). The references to the "insurance industry" in these cases thus are best understood as another way of saying "the industry of providing insurance." As the cases illustrate, it is sometimes enough to determine that the law regulates only insurers, for the practice in question may clearly be an insurance practice *if* it is an "insurer" doing it. For example, in *Rush Prudential* there was no question that the law affected the terms of HMO policies; the real question was whether the HMOs were acting as *insurers* in issuing those policies. Thus in *Rush Prudential* the answer to the "who" question also answered the critical "what" question. But where, as here, the law regulate *more* than insurers, it is less likely to be a law that regulates insurance, for who besides insurers engages in insurance practices? Even if the law regulates only insurers, then it is only likely (but not certain) to be a law that regulates "insurance," since states frequently regulate the non-insurance practices of insurers. *See supra* note 12. The bottom line is that regardless of who is actually being regulated, a law is saved from preemption if and only if it is regulating an *insurance* practice.

limited provider networks – that is *not* an "insurance practice," and they regulate entities that are *not* "insurers," by barring non-insurer providers who want to enter into financially beneficial limited network contracts with HMOs from doing so.[14] In short, AWP laws are "concerned generally with regulating provider access to networks rather than specifically regulating the business of insurance." Pet. App. 44a (Kennedy, J., dissenting). Thus, as a matter of common sense, AWP laws are not laws that "regulate insurance."

2. It is hardly surprising that the *Royal Drug* factors should uniformly confirm the common-sense conclusion, inasmuch as the Court derived the factors in the course of concluding that indistinguishable pharmacy provider contracts are not the business of insurance.

[14] Kentucky's AWP laws also apply to two *other* categories of entities that do not accept and spread risk. The first includes HMOs that provide only administrative services to non-ERISA employer-funded plans (*i.e.*, government and church plans). The court below held that the laws do not apply to HMOs acting as administrators to ERISA plans apparently on the ground that such a reading would be preempted by ERISA. Pet. App 26a, 28a n.14; *cf.* Pet. App. 45a. Even accepting that highly dubious reading of the laws, the statutes still would apply to every non-risk-bearing HMO providing services to state and local government plans and church plans, which are not governed by ERISA. The second category of non-insurers the statute governs are the self-funded government and church plans themselves. The Kentucky AWP laws do not apply to any plan governed by ERISA, but since government and church plans are not governed by ERISA, they are covered by the AWP laws. And any such plans governed by the law that are self-funded are not properly called "insurance": such plans involve neither the transfer nor the pooling of shared risks – but rather only the maintenance of a fund large enough to absorb predicted losses – and so they "involve[] no insurance as the term is ordinarily used in regulatory statutes or in other legal contexts." Keeton & Widiss, Insurance Law 14 (1988). Indeed, ERISA specifically bars states from deeming the self-funded plans it governs to be "insurance" for the purpose of the saving clause. 29 U.S.C. § 1144(b)(2)(B). Thus, Kentucky AWP laws explicitly bring within their sweep public-entity plans that, were they within the scope of ERISA, clearly would be designated non-insurers.

a. As discussed above, the first reason *Royal Drug* held that provider contracts are not the business of insurance is that they do not spread risk. *See supra* at 15-18. As also discussed above, the suggestion that either HMO provider contracts, or HMO insurance policies, differ from the contracts and policies at issue in *Royal Drug* is without merit. There can be no genuine dispute that HMO provider contracts do not spread or underwrite risk – the "primary element," "one earmark," the "indispensable characteristic," of insurance. Just as that fact alone sufficed in *Royal Drug* to resolve the question whether provider contracts constitute "insurance," it should suffice to answer the question here.

Despite the primacy of risk-spreading in *Royal Drug*'s conception of the practice of insurance, this Court has in two recent saving clause cases declined to address whether the law at issue governed a risk-spreading practice. *See Rush Prudential*, 122 S. Ct. at 2163; *UNUM*, 526 U.S. at 373. But in both instances, the Court held that the practice at issue "clearly satisfied" the other *Royal Drug* factors, *Rush Prudential*, 122 S. Ct. at 2163; *see UNUM*, 526 U.S. at 374 ("the remaining McCarran-Ferguson factors, verifying the common-sense view, are securely satisfied"). And that conclusion made sense in each case, for, as discussed above, the state law in each case directly regulated the terms of insurance contracts, and only insurance contracts. *See supra* at 28-29. It follows as a matter of course that such a law "regulates insurance": even under *Royal Drug*, if there is one thing that defines a law that regulates insurance in the absence of a risk-spreading analysis, it is that the law regulates the insurance contract. *See Royal Drug*, 440 U.S. at 215-16 (noting that the policy "relationship between insurer and insured" is at "the core of the 'business of insurance'"); *cf. Pireno*, 458 U.S. at 128 (same); *id.* at 136 (Rehnquist, J., dissenting) ("the Court [in *Royal Drug*] found the contractual relationship between the insurer and the insured to be the essence of the 'business of insurance'").

Evaluation of the risk-spreading factor cannot so readily be forgone here. Unlike *Rush Prudential* and *UNUM*, the common-sense inquiry and the other *Royal Drug* factors do not "clearly" or "securely" establish that third-party provider contracts are insurance practices. To the contrary, the other elements of the test strongly suggest such contracts are *not* insurance. And then there is this Court's own holding to exactly that effect in *Royal Drug*. It would be odd, indeed, for the Court to hold in this case that third-party provider contracts are "insurance" without considering the one factor the Court considered conclusive the last time it considered essentially the same question.

b. The second reason *Royal Drug* held that provider contracts are not insurance is that the terms of such contracts are not integral to the bargain between insurer and insured. *See supra* at 18-19. As already discussed, this Court has applied that factor in the context of the ERISA saving clause to find that several state laws do regulate insurance, but only where such laws directly affect the terms of the insurance policy. *See supra* at 28-29. By contrast, as we have emphasized, AWP laws do not alter any term of the bargain between insurer and insured.

The majority below fully acknowledged that "the AWP laws do not change the substantive terms of the insurance coverage," Pet. App. 36a, but concluded that the choice of provider is "integral" to the HMO policy only in the indirect sense that policyholders would be pleased to have the opportunity to obtain care from a provider of their choice, *id.* at 31a, 36a. That analysis is flawed in two respects.

First, it fundamentally misapprehends both the operation of HMO networks and the effect of AWP laws. HMO provider networks are often explicitly limited in size in order to control quality and cost, but they are also *implicitly* limited by the terms of the network contracts. In *Royal Drug*, for example, the network was nominally open to any pharmacy

willing to join, but in fact only high-volume chains could afford to provide drugs for the small, $2 mark-up required by the contracts. Similarly, the terms of HMO network contracts may price some or many providers out of the network, or impose practice conditions providers are unwilling to accept. A provider may also choose not to join a network simply because he or she is already a member of one or more other networks, or because he or she does not want to accept the management inherent in managed care. The critical point is this: AWP laws do not change *any* of those realities. That is, they require neither that HMOs open up their networks to all providers regardless of contract terms, nor that HMOs allow insureds to obtain care from any provider of their choice who has not joined the network. "The result," as Judge Kennedy correctly observed below, "is that although Kentucky's AWP laws make it *marginally* more likely that a policyholder's benefit plan network will contain their preferred doctor, they will still be restricted to the doctors in their benefit plan network regardless of the membership or non-membership of their preferred doctor." Pet. App. 51a (emphasis added). Accordingly, even the indirect effect the majority found to be so "integral" on the insurer-insured bargain occurs *only* when an insured's preferred provider "is both willing to join [the insured's] particular provider network and able to meet its requirements." *Id.* at 56a. To say that providing such a speculative, marginal benefit to an insured is "integral" to the entire policy, is to drain the second *Royal Drug* factor of any real meaning.

Second, even if AWP laws did work to give a substantial number of insureds a significantly broader range of providers to choose from, it is wrong to assume that the size and membership of the HMO's provider network is "integral" – or even germane – to the *contract of insurance* between insurer and insured. The nature of network options is certainly no more integral to an HMO policy than the pharmacy network options were integral to the insurance policies in *Royal*

Drug. As discussed above, *supra* at 25, many of the insureds in that case doubtless would have preferred to obtain drugs for $2 from their local druggists, rather than only from one of the large chains able to contract with the insurer. And yet the Court easily concluded that the insurer's decision to effectively limit insureds' options to one of the large providers was immaterial to the insurer-insured bargain: because the essence of that bargain was underwriting the risk of needing to pay for drugs, which was fully satisfied so long as the insurer made drugs available, insureds were "basically unconcerned" with the arrangements made by the insurer to control the costs of making drugs available. 440 U.S. at 214. So it is here: HMO policyholders may wish to obtain network service from a local doctor or pharmacist as much as the insureds did in *Royal Drug*, but that desire is not "integral" to the risks of loss that HMOs agree to accept, which is what the insurer-insured bargain is all about.

c. The final reason *Royal Drug* held that provider contracts are not insurance is that they involve entities outside the insurance industry – specifically, the providers with whom insurers contract. *See supra* at 19-20. This factor has been construed as examining whether the practice regulated by the law involves an "arrangement[] between insurance companies and parties outside the insurance industry." *Pireno*, 458 U.S. at 133. If the "targets of the law" are not "limited to entities within the insurance industry," then it is not a law that regulates insurance. *Rush Prudential*, 122 S. Ct. at 2164.

As demonstrated above in our discussion of the commonsense inquiry,[15] the targets of AWP laws are not limited to

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[15] Recent cases have treated the third *Royal Drug* factor as effectively identical to the common-sense inquiry into whether the law is "directed specifically to the insurance industry." *Rush Prudential*, 122 S. Ct. at 2162; *see id.* at 2164 (finding third factor "satisfied for many of the same reasons that the law passes the commonsense test"); *UNUM*, 526

HMOs; they include the doctors and other providers who seek the advantage of membership in limited networks. This Court's cases have uniformly recognized that contracts with such non-insurance entities fall outside the "business of insurance," even if they might be understood as within the "the broader 'business of insurance companies.'" *Hartford Fire Ins. v. California*, 509 U.S. 764, 783-84 (1993) (holding that agreements between insurers and reinsurers are within the business of insurance) (citation omitted); *see Pireno*, 458 U.S. at 131 (insurer's contract with providers to conduct peer review is outside the business of insurance); *Royal Drug*, 440 U.S. at 231. *None* of the Court's saving clause precedents has found a law regulating contracts between insurers and non-insurers (other than insurance policies themselves) to be a law that regulates insurance. A law regulating contracts that amount to "the mass purchase of [medical] services from outside the insurance industry," *Royal Drug*, 440 U.S. at 224, simply cannot be a law that regulates insurance. AWP laws thus plainly fail the third *Royal Drug* factor as well.[16]

3. The foregoing discussion confirms the relevance of *Royal Drug*'s analysis and specific holding to the ERISA saving clause context. The Court continues to apply the

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U.S. at 373 (relying entirely on common-sense discussion to explain why third factor met).

[16] To the extent the third *Royal Drug* factor now mirrors the common-sense inquiry, *see supra* note 15, it bears noting that the common-sense inquiry is not, in fact, limited exclusively to an examination of "who" is regulated by the law, *see supra* at 28-31 & n.13. The common-sense question ultimately is whether the law targets the *practice of insuring*. As discussed above, that inquiry may be well illuminated by evidence that the law applies only to insurers, but such evidence will not be sufficient in all cases: the law must regulate the *insurance* aspect of what insurers do. Because AWP laws regulate a practice (of both HMOs and providers) that is other than insurance, it necessarily fails the third *Royal Drug* factor for the same reasons it fails the common-sense inquiry.

Royal Drug factors in saving clause cases, and nothing in the Court's application of the factors in that context, nor in the common-sense inquiry that has been overlaid upon them, alters the conclusion that an insurer's contracts with third-party providers are not insurance.

There is thus no merit to the suggestion of the court below that this Court's decision in *United States Department of Treasury v. Fabe*, 508 U.S. 491 (1993), categorically diminishes the relevance of *Royal Drug*'s approach and holding in ERISA saving clause cases. Pet. App. 35a. In *Fabe*, this Court compared the scope of the two clauses of McCarran-Ferguson Act § 2(b): "The first clause commits laws 'enacted . . . for the purpose of regulating the business of insurance' to the States, while the second clause exempts only 'the business of insurance' itself from the antitrust laws." *Id.* at 504. The Court pointed out that the language of the first clause was not as "narrowly circumscribed" as the second, in that laws "*enacted for the purpose of* regulating the business of insurance" would cover more laws than just those that "specifically relate[] to the business of insurance." *Id.* (emphasis added). *Royal Drug*, the Court observed, construed only the narrower reference in the second clause. *Id.* at 505.

That discussion in no way suggests that *Royal Drug*'s conception of laws that "specifically relate to the business of insurance" is somehow narrower than the saving clause conception of laws that "regulate insurance." Indeed, the language of the saving clause bears a much greater resemblance to the narrower, second clause of McCarran-Ferguson § 2(b) addressed in *Royal Drug* than it does to the broader first clause. The saving clause saves laws that actually *do* "regulate insurance," not those enacted with the broader "*purpose* of regulating the business of insurance." The close linguistic similarity between the saving clause and the McCarran-Ferguson language addressed in *Royal Drug* is surely why this Court has continued to rely on the *Royal Drug* factors

for saving clause analysis, with no suggestion in any post-*Fabe* case that they are to be applied in the saving clause context more narrowly than they would apply under § 2(b).[17]

Finally, it bears emphasis that *Fabe* itself specifically restates *Royal Drug*'s holding "that an insurer's agreements with participating pharmacies to provide benefits to policyholders [are] not part of the 'business of insurance.'" *Id.* at 503. If *Fabe* itself did not circumscribe the authority of the *Royal Drug* factors in saving clause cases – and it plainly did not – then its reaffirmance of *Royal Drug*'s basic holding only underscores the continued force of that holding in the saving clause context.

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be reversed.

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[17] For the same reason, the Solicitor General's suggestion that the term "insurance" used in the saving clause invokes a broader definition of "insurance practices" than does the phrase "*business of* insurance" used in McCarran-Ferguson, *see* U.S. Pet. Br. 16, is incorrect. No precedent of this Court has suggested that the phrases have any materially different meaning. The *only* support offered for that argument is that the Court has added the common-sense inquiry to the analysis of insurance practices under the ERISA saving clause, *see id.*, as if that alone proves that "insurance" under the saving clause is broader than "the business of insurance." But the cases plainly have not employed a common-sense analysis in order to invoke a broader category of insurance practices than would be defined by McCarran-Ferguson. To the contrary, the cases specifically rely on the McCarran-Ferguson factors to "test" or "confirm" the common-sense inquiry, establishing – not refuting – the parallel between the statutes. *See also supra* note 11.

Respectfully submitted,

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Supreme Court of the United States

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., et al.,

Petitioners,

v.

JANIE MILLER, COMMISSIONER OF THE KENTUCKY DEPARTMENT OF INSURANCE,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

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QUESTION PRESENTED

The question presented is whether Ky. Rev. Stat. §304.17A-270, Kentucky's Any Willing Provider ("AWP") statute and Ky. Rev. Stat. §304.17A-171(2), the chiropractic AWP statute (referred to collectively as "Kentucky's AWP statutes"), are preempted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 et seq., or are they saved from preemption because they are state statutes that "regulate the business of insurance?"

PARTIES

Petitioner, Kentucky Association of Health Plans ("KAHP"), includes six insurers holding certificates of authority issued by the Kentucky Department of Insurance, pursuant to Ky. Rev. Stat. § 304.3-160, to transact the business of insurance as health maintenance organizations ("HMO") in the Commonwealth of Kentucky.[1] Other petitioners are Humana Health Plan of Ohio, Inc. ("Humana of Ohio"), which succeeded plaintiff-appellant Choicecare Health Plans, Inc. and Aetna Health Inc. (OH) ("Aetna of Ohio") which succeeded plaintiff-appellant Aetna Health Plans of Ohio, Inc. Humana of Ohio, is an insurer, which holds a certificate of authority issued by the Kentucky Department of Insurance to operate as an HMO, as is Aetna of Ohio.

HMPK, Inc. and HPLAN, Inc., also plaintiffs-appellants below, have been succeeded by petitioner Humana Health Plan, Inc. As stated above, Humana Health Plan, Inc. is a member of the KAHP. Advantage Care, Inc. and FHP of Ohio, Inc., also plaintiffs-appellants below, are no longer parties to this action and are not petitioners in this Court.

[1] The members include Anthem Health Plans of Kentucky, Inc. d/b/a Anthem Blue Cross and Blue Shield of Kentucky, Inc., Aetna Health Inc., Bluegrass Family Health, Inc., CHA HMO, Inc. d/b/a CHA Health, Humana Health Plans, Inc. and United HealthCare of Kentucky, Ltd.

PARTIES – Continued

Respondent, Janie A. Miller, succeeded to the position of Commissioner of Insurance for the Kentucky Department of Insurance (sometimes referred to as "The Department") after the Sixth Circuit Court of Appeals entered judgment in this case, and is accordingly substituted as respondent pursuant to S. Ct. R. 35.3.

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STATEMENT OF THE CASE

I. RELATIONSHIP OF THE PARTIES

Each Petitioner holds a certificate of authority issued by the Kentucky Department and, therefore, each Petitioner must comply with all applicable insurance statutes in Ky. Rev. Stat. Chapter 304 ("the insurance code") in order to keep its certificate of authority in good standing.[2] Each Petitioner is issued a certificate of authority that allows it to transact the business of insurance as an HMO.[3] As insurers, petitioners offer different types of health benefit plans including HMO plans, Preferred Provider Organization ("PPO") plans, and Point of Service ("POS") plans. PPO and POS health benefit plans offer both in-network and out-of-network benefits. Additionally, Anthem Blue Cross and Blue Shield offers a traditional fee-for-service plan. Because these plans are considered "health benefit plans" for the purposes of subtitle 17A of the insurance code, they must meet all the requirements of subtitle 17A.

Among her other duties and responsibilities required by statute, Commissioner Janie A. Miller is required to "inquire into violations of [the insurance code and] . . .

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[2] The commissioner may revoke or suspend an insurer's certificate of authority for willfully violating or willfully failing to comply with any provision of the insurance code. See Ky. Rev. Stat. § 304.3-200.

[3] In *Rush Prudential*, the Court recognized that HMOs "are almost universally regulated as insurers under state law." *Rush Prudential HMO, Inc. v. Moran*, 122 S.Ct. 2151, 2163 (2002). In Kentucky, petitioners are regulated as insurers.

enforce the provisions of [the insurance code] with impartiality and [to] execute the duties imposed upon [her] by [the insurance code]." Ky. Rev. Stat. § 304.2-100(2).

II. STATUTORY SCHEME

Like many state legislatures, the Kentucky General Assembly has struggled with the often-competing interests between healthcare insurers (cost-containment, managing care) and insureds (access to affordable but quality care). In 1994, the Kentucky General Assembly passed sweeping healthcare reform, which greatly affected the insurance code, particularly by the creation of subtitle 17A of Ky. Rev. Stat. Chapter 304.[4] Subtitle 17A governs all insurers doing business in the Commonwealth and issuing health benefit plans. "Insurer" is defined in Ky. Rev. Stat. 304.17A-005(23). "Health benefit plan" is defined in Ky. Rev. Stat. 304.17A-005(18). The 1994 health care reform was a culmination of two years of study and testimony conducted by the Kentucky General Assembly on the problems in the Kentucky health care system. The General Assembly enacted health care reform to respond to the following problems: (a) lack of insurance and inadequate access to health care; (b) financial barriers to access; (c) insurance marketplace practices; (d) administrative costs in private insurance policies; (e) market fragmentation and purchaser confusion; and (f) poor allocation of health care providers in the state. See *A Citizen's Handbook, Kentucky's Health Care Reform, A Profile of HB 250:*

[4] House Bill ("HB") 250, An Act relating to health care reform.

Provisions, Time Line, Q & A; Legislative Research Commission; Frankfort, Kentucky, May 1994.

The AWP provision was an integral part of the statutory scheme associated with Kentucky's 1994 healthcare reform. Kentucky's AWP provision is now codified in Ky. Rev. Stat. § 304.17A-270.[5] (Pet. App. 89a) In 1996, the Kentucky General Assembly enacted an additional AWP provision that required all insurers issuing health benefit plans that included chiropractic benefits to allow any chiropractor, who was willing to agree to the terms and conditions set by the insurer, to participate in the health benefit plan. (Pet. App. 89a-91a). Kentucky's chiropractic AWP is codified in Ky. Rev. Stat. § 304.17A-171(2). Since 1994, the Kentucky General Assembly has continued to struggle with the competing interests of insurers and insureds, resulting in some of the HB 250 patient protections being repealed. However, Kentucky's AWP statutes remain in force.[6]

The General Assembly passed Kentucky's AWP statutes as an integral and necessary part of health care reform. As with most added, and sometimes mandated, consumer benefits to insurance policies, Kentucky's AWP statutes may increase the cost on insurers as Petitioners

[5] Kentucky's AWP was originally codified in Ky. Rev. Stat. § 304.17A-110(3) but was later recodified in Ky. Rev. Stat. § 304.17A-270, changing the phrase "health care benefit plans" to "health insurer."

[6] In 2000, the Kentucky General Assembly passed HB 757, another patient protection bill. That bill amended Ky. Rev. Stat. § 304.17A-505 requiring insurers offering managed care plans to disclose to their insureds, upon enrollment and upon request, that the insurer will take any willing provider. This law has not been challenged.

maintain. (Pet. Br. 5, fn. 4). However, the Kentucky General Assembly decided, rightly or wrongly, that the need for and benefits of an AWP law for insureds outweighed the possibility of increased costs for insurers.[1]

III. PROCEEDINGS BELOW

Petitioners continue to maintain that Kentucky's AWP statutes are preempted by ERISA as they "relate to" and have a "connection with" employee welfare benefit plans and are not "saved" from preemption as they do not regulate the business of insurance.

The Sixth Circuit Court of Appeals agreed with Petitioners that Kentucky's AWP statutes are "related to" and have a "connection with" employee welfare benefit plans; however, a majority of the Court concluded that these statutes were saved from preemption because they

[1] The issue of whether AWP laws increase costs and by how much is open to debate. See James W. Childs, Jr., *You May Be Willing, But Are you Able?: A Critical Analysis of "Any Willing Provider" Legislation*, 27 Crumb. L. Rev. 199, 212 (1996-1997) ("[T]here is some evidence that health care costs have not risen in those states which have enacted AWP legislation.") However, the issue of cost is irrelevant to the discussion of whether the law in question is a law that regulates insurance. Mandated benefits, and other consumer protections, increase cost. See The Factors Fueling Rising Healthcare Cost, prepared by PriceWaterhouseCoopers for American Association of Health Plans, April 2002, *available at* www.aahp.org/Internallinks/PWCFinal Report.pdf. However, mandated benefit laws are laws that regulate the business of insurance. *Metropolitan Life v. Massachusetts*, 471 U.S. 724 (1985). The Sixth Circuit agreed the cost is not relevant to the discussion – "the decision of the Kentucky legislature to enact AWP laws is one left to the wisdom of that deliberative body, and the possible economic ramifications of its AWP laws should not concern this court." Pet. App. 34a, fn. 18.

"regulate insurance." Pet. App. 7a-19a; *id.* at 38a. Concluding as such, the Sixth Circuit affirmed the decision of the United States District Court for the Eastern District of Kentucky.

Relying on the "common-sense" test as set forth in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 740 (1985) and *UNUM Life Insurance of America v. Ward*, 526 U.S. 358, 367 (1999), the Sixth Circuit concluded that Kentucky's AWP statutes are saved from preemption because they are statutes that "meet[] the common sense test in that [they] clearly [do] regulate insurance." *Id.* at 20a-30a. The Sixth Circuit also found that Kentucky's AWP statutes are saved from preemption because they meet the "three factors employed to determine whether the regulation fits within the 'business of insurance' as that phrase is used in the McCarran-Ferguson Act." *Id.* at 20a, citing, *UNUM*, 526 U.S. at 367-68.

Even though the Sixth Circuit found that Kentucky's AWP statutes meet the three McCarran-Ferguson factors, it noted that this Court, in *UNUM*, established that the three McCarran-Ferguson factors "are not required to be satisfied before a state law can be found to be a law regulating insurance." *Id.* at 38a. Instead, the three McCarran-Ferguson factors are "checking points" or "guideposts" for the courts. *Id.* The fact that a state law does not have to meet all three McCarran-Ferguson factors to survive preemption was reiterated last term in *Rush Prudential HMO, Inc. v. Moran*, 122 S.Ct. 2151 (2002) (finding that Illinois' external review law meets two of the three McCarran-Ferguson factors and is a law that

regulates the business of insurance and, therefore, is saved from preemption).

SUMMARY OF THE ARGUMENT

I. Petitioners are insurers holding certificates of authority issued by the Kentucky Department of Insurance. Therefore, Petitioners must comply with the state regulatory requirements of Kentucky's AWP statutes. Petitioners must comply with Kentucky's AWP statutes regardless of whether they issue a health benefit plan in the individual, association, or fully insured large or small group market. Kentucky's AWP statutes provide the benefit of an open panel for all individuals covered under a Kentucky health benefit plan. Because Kentucky's AWP statutes confer a benefit on employees covered under a fully insured employee benefit plan, these statutes have a "connection with" fully insured employee benefit plans.

II. Kentucky's AWP statutes are laws that "regulate insurance" within the meaning of ERISA's saving clause. Kentucky's AWP statutes meet the two-prong test used by courts to determine whether a law "regulates insurance" within the meaning of the saving clause.

As a matter of common sense, both of these statutes regulate insurance because they are specifically directed at the insurance industry and they regulate insurance practices within that industry. In addition, both of these statutes meet all three McCarran-Ferguson factors, confirming that they are laws that "regulate insurance" as a matter of common sense. Kentucky's AWP statutes operate to spread risk by providing a greater benefit to Kentucky insureds similar to the mandated mental health benefit in *Metropolitan Life*. These laws also mandate a

contract term between the insurer and the insured and are an integral part of the insurer/insured relationship similar to the external review law in *Rush Prudential*. Finally, Kentucky's AWP laws are requirements imposed only on Kentucky insurers, issuing health benefit plans, and, therefore, are laws that are limited to the insurance industry.

III. Kentucky's AWP statutes are a state regulatory scheme to benefit insureds and, therefore, are distinguishable from the private pharmacy agreements that were the subject of an antitrust action in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). The insurer, in *Royal Drug*, attempted to enter into pharmacy agreements as a business decision to lower its costs. Kentucky's AWP statutes function in a completely different manner than the private pharmacy agreements in *Royal Drug*. These statutes regulate the insurance practice of arbitrarily limiting provider panels. These statutes also confer a benefit on Kentucky insureds by providing greater access to health care. Therefore, Kentucky's AWP statutes regulate the business of insurance.

ARGUMENT

I. KENTUCKY'S AWP STATUTES PROVIDE THE BENEFIT OF GREATER ACCESS TO CARE FOR INDIVIDUALS COVERED UNDER HEALTH BENEFIT PLANS ISSUED BY KENTUCKY INSURERS REGARDLESS OF WHETHER THE POLICY IS ISSUED TO AN INDIVIDUAL, ASSOCIATION, OR FULLY INSURED EMPLOYER GROUP

Any ERISA preemption analysis must first start with whether the state law at issue "relates to" employee

benefit plans. Under Section 514(a) of ERISA, 29 U.S.C. § 1144(a), the provisions of ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." To determine whether a state law "relates to" an employee benefit plan "yield[s] a two-part inquiry: A law 'relate[s] to' a covered employee benefit plan for purposes of § 514(a) 'if it [1] has connection with or [2] reference to such a plan.'" *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 324 (1997) (citation and internal quotation marks omitted).

Next, an ERISA preemption analysis requires a determination as to what is the "plan." "Rules governing collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services are the sorts of provisions that constitute a plan." *Pegram v. Herdrich*, 530 U.S. 211, 223 (2000), citing *Hansen v. Continental Ins. Co.*, 940 F.2d 971, 977 (C.A.5 1991). An "agreement between an HMO and an employer who pays premiums may . . . provide elements of a plan by setting out rules under which beneficiaries will be entitled to care." *Pegram*, *supra* at 223. When an employer decides to purchase insurance rather than self-insure, an insurer's provider directory, and certificate of coverage, issued to plan beneficiaries, provide elements of the employee benefit plan. The certificate of coverage and provider directory inform the plan participant and beneficiary how they access providers and which providers they may access.[8]

[8] Upon enrollment, the certificate of coverage in Joint Appendix C (pages 21a-106a) is given to a plan participant along with a provider directory as required by Ky. Rev. Stat. § 304.17A-590 and Ky. Rev. Stat.
(Continued on following page)

A. Kentucky's AWP statutes relate to ERISA plans to the extent that they mandate a benefit structure for fully insured ERISA plans.

The Department acknowledges that Petitioners, because they are companies licensed to transact the business of insurance in the Commonwealth, can and do issue health benefit plans to employer groups. (See Joint Appendix 21a-106a). Because Kentucky's AWP statutes "mandate[] employee benefit structures" for insured employee benefit plans by requiring open networks rather than closed, they have a "connection with" ERISA plans. Cf. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995) (holding that a New York statute requiring hospitals to collect a surcharge from patients who are covered under ERISA plans not "related to" employee benefit plans). Kentucky's AWP statutes bear "indirectly but substantially on all insured benefit plans," *Metropolitan Life*, 471 U.S. at 739, by requiring employers that choose not to self-insure to purchase a health benefit plan that provides greater access to health care providers for plan participants and beneficiaries. An individual covered under a self-insured plan would only have access to a limited panel of providers dictated solely by the employer plan.

§ 304.17A-510. The certificate includes definitions of terms used in the certificate. Non-participating hospital, non-participating physician, and non-participating provider are defined on page 28a. Participating hospital, participating physician, and participating provider are defined on page 29a. On page 61a, the certificate provides information to the plan participant and beneficiary regarding the difference in cost (risk sharing) if they receive services rendered by non-participating physicians rather than a participating physician.

Insurance regulation, by its very nature, places requirements on insurers and the plans they offer. These state regulatory requirements, like Kentucky's AWP statutes, do not disappear even when an insurer offers policies to employers and covers employees in insured employee benefit plans. However, this does not change the fact that Kentucky's AWP statutes, or other insurance statutes, are laws that regulate the business of insurance and are, therefore, saved from ERISA preemption under 29 U.S.C. § 1144(b)(2)(A).[9]

B. Kentucky's AWP statutes are insurance laws that are directed toward insurers issuing health benefit plans in the Kentucky insurance market.

It is important to note what Kentucky's AWP statutes do not do. They do not single out ERISA plans for differing treatment. Cf. *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988) (Georgia antigarnishment statute singled out ERISA plans for protective treatment and, therefore, was preempted). Kentucky's AWP statutes are not dependent on ERISA plans for its operations. Cf. *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125 (1992) (state law that required employers who provide health insurance for their employees to provide equivalent health insurance coverage for

[9] The nature of state insurance regulation, along with ERISA's preemption language and saving clause, demonstrates how ERISA's language "seems simultaneously to preempt everything and hardly anything" at the same time. *Rush Prudential*, 122 S.Ct. 2151, 2159 (2002).

injured employees eligible for worker's compensation was premised on the existence of ERISA plans). Petitioners are required to provide the benefit of open panels, as required by Kentucky's AWP statutes, when issuing any health benefit plan regardless of whether the health benefit plan is issued in the individual, association or group market.

Furthermore, Kentucky insurance statutes do not "deem" employee benefit plans to be insurance companies or insurers for the purposes of regulating them as such in violation of Section 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B), which prevents states from regulating self-insured plans under the guise of regulating insurance. See *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990). Instead, Ky. Rev. Stat. § 304.17A-005(23) acknowledges the "deemer clause" and adheres to the requirements of that clause by defining insurer as "any insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement *not exempt from state regulation by ERISA*" (Pet. App. 89a, emphasis added). Simply put, the Kentucky Department of Insurance does not regulate self-insured ERISA plans as insurance companies.

Considering the recent decision in *Rush Prudential*, 122 S.Ct. 2151 (2002), the Kentucky Department of Insurance acknowledges that, to the extent that Kentucky's AWP statutes mandate a benefit structure for fully insured employer groups, they "relate[] to" ERISA plans.

II. KENTUCKY'S AWP STATUTES REGULATE INSURANCE AND ARE SAVED FROM PREEMPTION

A state law is saved from preemption if it is a law that "regulates insurance." 29 U.S.C. § 1144(b)(2)(A). In *UNUM*

Life Ins. Co. of America v. Ward, 526 U.S. 358 (1999), the Court reaffirmed the two-prong test used in *Metropolitan Life* to determine whether a state law "regulates insurance" within the meaning of the ERISA saving clause. First, a court determines whether the state law regulates insurance from a common-sense view of the matter. Second, a court considers the three factors employed to determine whether the state law is a law that regulates the "business of insurance" as that phrase is used in the McCarran-Ferguson Act, 15 U.S.C. § 1012(a). The three McCarran-Ferguson factors are as follows: (1) whether the practice transfers or spreads risk; (2) whether it is an integral part of the insurer-insured relationship; and (3) whether the practice is limited to entities within the insurance industry. *UNUM*, 526 U.S. at 367-68. "Because the [McCarran-Ferguson] factors are guideposts, a state law is not required to satisfy all three ... criteria to survive preemption." *Rush Prudential*, supra at 2163.

As the Sixth Circuit correctly concluded, as a matter of common sense, Kentucky's AWP statutes regulate insurance and meet the three McCarran-Ferguson factors.

A. As a matter of common sense, Kentucky's AWP statutes regulate insurance.

1. The decision in *Rush Prudential* confirms that Kentucky's AWP statutes are directed toward the insurance industry.

The Sixth Circuit's determination that Kentucky's AWP statutes regulate insurance "as a matter of common sense," Pet. App. 19a-30a, is in compliance with this Court's precedents, including the most recent decision in

Rush Prudential. In *Rush Prudential*, it was reiterated that when "deciding whether a law 'regulates insurance' under ERISA's saving clause, [the Court will] start with a 'common-sense view of the matter.'" *Rush Prudential*, 122 S.Ct. at 2159, quoting *Metropolitan Life v. Massachusetts*, 471 U.S. at 740. Under the common sense view, "a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987); see *Rush Prudential*, 122 S.Ct. at 2159. Like the Illinois external review law considered in *Rush Prudential*, Kentucky's AWP statutes are "'directed toward' the insurance industry, and [are] 'insurance regulation[s]' under a 'commonsense' view." *Rush Prudential*, supra at 2163.

Only an "insurer," as defined in Ky. Rev. Stat. § 304.17A-005(23), issuing a "health benefit plan," as defined in Ky. Rev. Stat. § 304.17A-005(18) is required to comply with Kentucky's AWP statutes.[10] The Kentucky Department of Insurance is charged with the responsibility of issuing certificates of authority to all risk-bearing entities conducting the business of insurance in the Commonwealth.[11] Ky. Rev. Stat. § 304.3-150 and

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[10] Besides Petitioners, the Department of Insurance also issues certificates of authority to Property and Casualty insurers with a health insurance line of authority and Life and Health insurers. Some of these insurers issue health benefit plans that are PPO products. When these insurers issue health benefit plans, regulated under Ky. Rev. Stat. Chapter 304, subtitle 17A, and enter into provider agreements, they must also comply with Kentucky's AWP statutes. Most, if not all, of these insurers offer health benefit plans exclusively in the individual market and not to employer groups.

[11] The Kentucky Department of Insurance does not issue certificates of authority to any employer who chooses to have a self-insured

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§ 304.3-160. The Kentucky Department of Insurance is charged with the duty of enforcing all applicable statutes in Ky. Rev. Stat. Chapter 304 against all insurers holding valid certificates of authority. Kentucky's AWP statutes are located in subtitle 17A of the insurance code and are directed solely at those regulated entities issuing health benefit plans, including Petitioners. For these reasons, the Sixth Circuit correctly determined that Kentucky's AWP statutes "are [ ] specifically directed toward 'insurers' and the insurance industry and are ones that from a 'common sense view' regulate insurance." Pet. App. 25a. In reviewing that determination, this Court does not "normally disturb an appeals court's judgment on an issue so heavily dependent on analysis of state law." *UNUM*, 526 U.S. at 368.

2. Kentucky's AWP statutes regulate the insurance practices of Kentucky insurers by prohibiting them from arbitrarily limiting access to providers.

Petitioners assertion that Kentucky's AWP statutes "regulate neither insurers exclusively, nor the insurance practice of insurers" is completely without merit. See Pet. Br. p. 27. If Petitioners believe, as they contend, that allowing an enrollee a larger panel of health care providers to choose from is not a benefit to the enrollee, the Department submits that Petitioners are completely disconnected from the individuals they insure. As an insurance practice, Petitioners want to limit their provider

employee benefit plan. Therefore, self-insured employer groups are not considered insurers in the Commonwealth of Kentucky.

networks for their benefit and to the detriment of their insureds. This insurance practice is similar to an insurer's decision to not offer a benefit, limit the coverage of a benefit, or deny coverage of a benefit based solely on an internal decision of medical necessity. When the need arises, it is up to the states to regulate these insurance practices through laws such as mandated benefit laws, external review laws, and AWP laws. These patient protection laws shift some of the risk from the insured onto the insurer by prohibiting the insurer from placing limitations on access to care.

Insureds obtain their benefits through the health insurance contract and the certificates of coverage issued pursuant to that contract. Insurers deliver provider directories simultaneously with the certificates of coverage. The Department contends that certificates of coverage and provider directories are so interrelated as to make them virtually indistinguishable. Contained within all certificates of coverage are "plan delivery rules." Within the limitations set forth by state regulation, the insurer sets the rules. Those rules inform the insured of the "how, when, where, and why" he or she may see a provider. Insurers contract with providers for the benefit of their insureds. The insurance code contains numerous statutes that require the Department to regulate the insurer-provider relationship.[12] The Department enforces these

[12] The Department of Insurance requires managed care plans to demonstrate that "[a] provider network [is] . . . available to all persons enrolled in the plan within thirty (30) miles or thirty (30) minutes of each person's place of residence, to the extent those services are available." Ky. Rev. Stat. § 304.17A-515(1)(e). Insurers are required to file sample provider agreements with the Department. Ky. Rev. Stat.

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statutes for the benefit of insureds. See *Department of Treasury v. Fabe*, 508 U.S. 491 (finding that an Ohio liquidation statute furthered the goal of protecting policyholders and was a law enacted to regulate the "business of insurance.") Common sense tells us that unless there is a

§ 304.17A-527 and 806 Ky. Admin. Regs. 17:300. "A contract between a managed care plan and a physician shall not require the mandatory use of a hospitalist." Ky. Rev. Stat. § 304.17A-532. Insurers issuing managed care plans are prohibited from entering into contracts with providers that contain language that limit the provider's disclosure of information to the enrollee regarding the enrollee's medical condition or treatment. Ky. Rev. Stat. § 304.17A-530. Provider agreements shall contain "hold harmless" clauses pursuant to Ky. Rev. Stat. § 304.17A-527(1)(a). Provider agreements shall contain a "continuity of care" clause. Ky. Rev. Stat. § 304.17A-527(1)(b). Managed care plans are required to notify an enrollee if his or her primary care provider has been terminated from the plan. Ky. Rev. Stat. § 304.17A-525(3). When deciding whether to issue a certificate of authority to an HMO, the Commissioner may consider an HMOs provider agreements by provider type. Ky. Rev. Stat. § 304.38-060(2)(d). The Department regulates an insurer's responsibility to promptly pay a clean claim to a provider. Ky. Rev. Stat. § 304.17A-700 et.seq. The Department regulates the type of claims forms that insurers can require providers to use. Ky. Rev. Stat. § 304.14-135. As part of an insurer's responsibility to disclose the terms and conditions of a health benefit plan, the insurer must have "[m]easures in place to ensure the confidentiality of the relationship between an enrollee and a health care provider." Ky. Rev. Stat. § 304.17A-505(1)(h). Additionally, an insurer must inform an insured or an enrollee "that if the provider meets the insurer's enrollment criteria and is willing to meet the terms and conditions for participation, the provider has the right to become a provider for the insurer." Ky. Rev. Stat. § 304.17A-505(1)(k). A managed care plan is required to ensure that an enrollee has an adequate choice of participating primary care providers. Ky. Rev. Stat. § 304.17A-520. A managed care plan is required to develop comprehensive quality assurance standards to ensure their members are receiving and have access to quality health care services. Ky. Rev. Stat. § 304.17A-545.

meaningful insurer-provider relationship, there is no true benefit to the consumer.

Like the mandated benefit law in *Metropolitan Life* and the external review law in *Rush Prudential*, Kentucky's AWP statutes specifically regulate the terms of the insurance contract by allowing greater access to care and, thus, providing a richer benefit for the insured.

B. Kentucky's AWP statutes meet the McCarran-Ferguson factors.

The Sixth Circuit ruled that Kentucky's AWP statutes meet all three McCarran-Ferguson factors. Pet. App. 30a-38a. This conclusion is correct. The McCarran-Ferguson factors confirm that Kentucky's AWP statutes are laws that regulate the business of insurance as a matter of common sense.

"[I]nsurance [is] a mechanism for shifting risk from one party to another in return for a premium payment, [and] every policy of insurance specifies which risk or risks that the insurer agrees to assume in return for the premiums called for by the insurance contract." 7 *Couch on Insurance*, § 101:1 (3d ed. 1997). Relying on the reasoning in *Stuart Circle Hospital Corp. v. Aetna Health Management*, 995 F.2d 500, 503 (4th Cir. 1993), *cert. denied*, 510 U.S. 1003 (1993), the Sixth Circuit concluded that Kentucky's AWP statutes satisfy the first McCarran-Ferguson factor because it has the effect of "transferring or spreading the policyholder's risk."[13] Pet. App. 30a. An insurer

[13] In *Stuart Circle*, the 4th Circuit concluded that Virginia's AWP statute related to ERISA plans but was saved from preemption because

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issuing an HMO, PPO, or POS health benefit plan must specify the in-network and out-of-network benefit for the insured. Thus, the insurer specifies which risk or risks the insurer is going to assume with regard to the insured's access to providers.

It is without a doubt that a patient's relationship with his or her health care provider is unique. It is a relationship based solely on trust. If an insurer arbitrarily prohibits a provider from participating in its network, many insureds, based on the relationship of trust and to ensure continuity of care, will choose to see the excluded provider.[14] In that situation, an insured enrolled in an HMO health benefit plan (no out-of-network benefit) will have to pay out-of-pocket to access that out-of-network provider – transferring the risk to the insured. If the insured is enrolled in a PPO or POS health benefit plan (with out-of-network benefits), the insured will take on additional liability to access the excluded provider of his or her choice.

Unlike the pharmacy agreements in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 214

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it regulated the business of insurance by spreading the cost component of policyholder's risk among all insureds because it "affects the type and cost of treatment available to an insured." *Stuart Circle*, 995 F.2d at 503. Additionally, the statute was an integral part of the policy relationship between insurer and insured, and the statute was expressly limited to entities within the insurance industry.

[14] In rural Kentucky, providers are scarce. Many areas of Kentucky are not close to an urban center. Additionally, many consumers only have one choice of insurer. Without Kentucky's AWP statutes, insurers would be allowed to further limit the choice of providers for Kentucky insureds.

(1979), Kentucky's AWP statutes are much more than "merely arrangements for the purchase of goods and services." To argue that an insured's preference for a particular health care provider, who has unique skill, experience, education, and personality, is similar to the pharmacy agreements in *Royal Drug* misses the point of AWP. Unlike Kentucky's AWP statutes, the pharmacy agreements in *Royal Drug* were created by the insurer to "minimize the cost[] Blue Shield incur[red] in fulfilling its underwriting obligations." *Id.* at 213. Instead, Kentucky's AWP statutes were the result of patient protection legislation to increase access to health care for insureds. An insured has an interest in and will have a preference for the health care provider who delivers the health care benefit under the policy. Petitioners would have this Court believe that insureds are no more concerned with whom their insurer contracts with to provide their health care services than they are with whom their insurer contracts with for janitorial services. This simply is not true.

Because insureds have a personal interest in their health care provider and will choose a provider to ensure the continuity of their care, Kentucky's AWP statutes transfer risk to insurers by reducing the possibility that insureds will have to pay out-of-pocket to see an out-of-network provider.

The second McCarran-Ferguson factor is also met. Kentucky's AWP statutes are "an integral part of the policy relationship between the insurer and the insured." *Rush Prudential*, 122 S.Ct. at 2163, quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982). The Sixth Circuit found this to be "unquestionably" true. Pet. App. 35a.

Kentucky's AWP statutes clearly affect the relationship between the insurer and the insured.[15] As stated previously, the certificate of coverage contains the "how, when, where, and why" of accessing a provider – the person who confers the benefit. As a matter of both law and function, the certificate of coverage cannot exist independently from the list of providers with whom the insurer has contracted.[16] This is especially true in Kentucky where most insurers, including Petitioners, issue managed care insurance policies (HMO, PPO, and POS). The certificate of coverage, along with the provider directory, "translate[] the relationship under the . . . agreement into concrete terms of specific obligation or freedom from duty." *Rush Prudential*, 122 S.Ct. at 2163.

Unlike the pharmacy agreements, in *Royal Drug*, Kentucky's AWP statutes are not simply a business decision made by insurers to reduce cost. Instead, Kentucky's AWP statutes function as a regulated mandate on insurers

[15] A hypothetical example of how AWP statutes work is as follows: A woman, in her second trimester of pregnancy, changes jobs either out of choice or necessity. She enrolls with her new employer's fully insured health benefit plan. She receives her certificate of coverage and provider directory. Upon reading the insurance materials, she notices that her obstetrician is not a listed provider. Understandably, she becomes concerned. When she contacts her insurer, her insurer is required to disclose that they will contract with any willing provider. Ky. Rev. Stat. § 304.17A-505(1)(k). She discusses this option with her obstetrician in order to have him contract with her insurer so that he can continue providing her with prenatal care. Kentucky's AWP statutes increase continuity of care, portability, and confer a benefit on the insured.

[16] Again, see Ky. Rev. Stat. § 304.17A-510 and Ky. Rev. Stat. § 304.17A-590 requiring an insurer to deliver the provider directory to the insured upon enrollment.

to offer a greater choice of providers to insureds and, thus, these statutes "change[] the bargain between insurer and insured." See *UNUM*, 526 U.S. at 374 (holding that California's notice-prejudice rule, which required the insurer to show actual prejudice from the insured's failure to give timely notice of claim, was an integral part of the policy relationship between insurer and insured). For these reasons, the second McCarran-Ferguson factor is met.

As the Sixth Circuit concluded, and for the same reasons that Kentucky's AWP statutes meet the common sense test, the third McCarran-Ferguson factor is met. Kentucky's AWP statutes are limited to entities within the insurance industry. Petitioners are insurers under Kentucky law. They hold certificates of authority issued by the Department of Insurance and, thus, fall under the regulatory authority of the Commissioner of Insurance. Unlike what Petitioners argue, Kentucky's AWP statutes do not apply to "entities acting solely as plan administrators"[17] Pet. App. 36a. Kentucky's AWP statutes, as written and as enforced, are laws regulating the business of insurance.

Although Kentucky's AWP statutes meet all three McCarran-Ferguson factors, "[i]t must be reiterated and emphasized that the three McCarran-Ferguson factors are not required to be satisfied before a state law can be found to be a law regulating insurance." Pet. App. 38a; see also *Rush Prudential*.

[17] Under Kentucky law, administrators do not and cannot issue "health benefit plans" as they are not insurers.

III. PETITIONERS' RELIANCE ON *ROYAL DRUG* IS MISPLACED.

By relying on the 1979 antitrust case of *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), Petitioners have demonstrated their lack of understanding of the focus and need for Kentucky's AWP statutes. These statutes do not attempt to regulate the contract between the insurer and provider. Instead, they are intended to regulate the benefit of greater access to health care for insureds covered under Kentucky health benefit plans.

Royal Drug held that agreements between insurers and pharmacists were not exempt from the federal antitrust laws under Section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. § 1012(b) because the agreements did not satisfy any of the McCarran-Ferguson factors. The insurer, in *Royal Drug*, attempted to enter into agreements with all pharmacies. The agreements allowed the insured to purchase drugs from a participating pharmacy for two dollars and, in return, the insurer would reimburse the pharmacy for the actual cost of the drugs. The non-participating pharmacies filed an antitrust action alleging that the insurer "had violated § 1 of the Sherman Act, 15 U.S.C. § 1, by entering agreements to fix the retail prices of drugs and pharmaceutical." *Id.* at 207. The insurer responded that its pharmacy agreements are the "business of insurance" and, therefore, are regulated by the state.[18]

[18] § 2(b) of the McCarran-Ferguson Act states "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance."

The majority in *Royal Drug* concluded that the insureds were "basically unconcerned with arrangements made between [the insurer] and participating pharmacies" and, therefore, the agreements did not fall under the business of insurance. *Id.* at 214. In *Royal Drug*, the insurer entered into the agreements with the participating pharmacy solely to set the reimbursement rate for the pharmacy. The decision to enter into these pharmacy agreements was a business decision made by the insurer.[19] Unlike the pharmacy agreements in *Royal Drug*, Kentucky's AWP statutes confer a benefit of choice and greater access on Kentucky's insureds.[20] Kentucky's AWP statutes determine who can be included in the insurer's network and, therefore, are of direct concern and benefit to the insured.[21] Unlike the private agreements in *Royal Drug*, the focus of Kentucky's AWP statutes is state regulation prohibiting the insurance practice of arbitrarily limiting provider panels.

It must be "presum[ed] that Congress did not intend to preempt areas of traditional state regulation." *Metropolitan Life*, 471 U.S. at 741, citing *Jones v. Rath Packing*

[19] The exemption in the McCarran-Ferguson Act is "for the 'business of insurance,' not the 'business of insurers.'" *Royal Drug*, 440 U.S. at 211.

[20] The concept of choice refers to the choice of provider to deliver a particular medical service. While one pharmacy may provide better customer service, there is no difference in the medical service. The prescription drug from the participating pharmacy is the same prescription drug available to the non-participating pharmacy.

[21] Kentucky's AWP statutes only confer the benefit of those providers listed in Ky. Rev. Stat. § 304.17A-005(19) on insureds. The Department has not promulgated any regulations to expand the list of providers in Ky. Rev. Stat. § 304.17A-005(19).

Co., 430 U.S. 519, 525 (1977). Kentucky's AWP statutes are the types of state regulation of insurance contemplated by and allowed for under ERISA's saving clause. Unlike in the context of an exemption from the federal antitrust laws, which must be construed narrowly, *Department of Treasury v. Fabe*, 508 U.S. 491, 505 (1993), "[t]he presumption is against preemption" under the ERISA's saving clause. *Metropolitan Life*, 471 U.S. at 741.

For these reasons, the pharmacy agreements in *Royal Drug* are wholly distinguishable from the state regulatory scheme of Kentucky's AWP statutes.

CONCLUSION

For the foregoing reasons, the judgment of the Sixth Circuit Court of Appeals should be affirmed.

Respectfully submitted,

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Supreme Court of the United States

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., *et al.*,
Petitioners,

v.

JANIE MILLER, COMMISSIONER OF THE KENTUCKY DEPARTMENT OF INSURANCE,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

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REPLY BRIEF FOR PETITIONERS

Respondent and her amici rest their contention that AWP laws "regulate insurance" principally on the ground that, by preventing HMOs from limiting the number of providers with whom they will contract to provide health services to members, AWP laws confer a valuable insurance benefit on HMO members. AWP laws do no such thing. AWP laws confer rights *solely on providers*, who may elect to join a network if they are willing to accept the terms set by the HMO. Contrary to the suggestions of respondent and her amici, Kentucky's AWP laws do *not* give HMO members the right to obtain care from any provider they choose. Notwithstanding AWP laws, HMO members may only obtain care from providers who have agreed to the terms of the HMO network contract, and the choice whether to do so remains entirely with the provider. As respondent's own amici state, AWP laws "directly and primarily regulate[] the relationship between the insurer and the health care service provider." AMA Br. 25. They do *not* regulate the relationship between the HMO and its members. Because there is no sense in which the rights conferred on providers by AWP laws also reflect a legal alteration in the terms of the insurance relationship between HMOs and their members, there is no sense in which AWP laws "regulate insurance" within the meaning of ERISA's saving clause.

There is therefore also no reason to depart from this Court's holding in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), that an insurer's contracts with health care providers to provide care to its insureds do not constitute an "insurance" practice. Respondent and her amici labor mightily to distinguish *Royal Drug*, but their efforts are unavailing.

Two principal grounds are suggested for escaping the dispositive force of *Royal Drug*. The first is that the question in *Royal Drug* was whether provider contracts are

business decisions that constitute "insurance," whereas here the question is whether *laws* that regulate those decisions are laws that "regulate insurance." Resp. Br. 23; *see* SG Br. 23. That distinction lacks merit: if the provider agreements in *Royal Drug* were not "insurance," then laws that regulate those agreements are not laws that regulate "insurance."

The second is that *Royal Drug* arose under the McCarran-Ferguson Act, and the test for "insurance" mandated under McCarran-Ferguson differs materially from the test required by the ERISA saving clause. Resp. Br. 23-24; SG Br. 24-27. This Court's precedents refute that contention. From their inception, this Court's ERISA saving clause decisions have used *exactly* the test devised in *Royal Drug* to determine whether the practice being regulated by a challenged state law is an "insurance" practice. To be sure, the ERISA test *also* incorporates a "common sense" component, but no case has ever held, or even intimated, that a law regulating a practice that is *not* "insurance" under McCarran-Ferguson can nevertheless be a law that regulates "insurance" under ERISA. In any event, even the additional "common sense" inquiry invoked under ERISA compels the same result. AWP laws do not regulate "insurers" exclusively (they also regulate non-insurer providers) and they do not regulate the "insurance" contract at all (they do not affect insureds' legal rights directly or indirectly).

AWP laws do not "regulate insurance" as a matter of law, as a matter of precedent, or as a matter of common sense. They are therefore preempted by ERISA.

ARGUMENT

The court below unanimously agreed that Kentucky's AWP laws "relate to" ERISA plans. Pet. App. 7a-19a, 24a-25a. Neither party sought review of that holding in this Court, and both parties agree that this threshold question of preemption is satisfied here. Resp. Br. 9; Petrs. Br. 12-13.

The Solicitor General, speaking for the Department of Labor, concurs. SG Br. 9-10.[1]

Accordingly, the parties before this Court agree that Kentucky's AWP laws are preempted unless they fit within ERISA's "saving clause" exemption from preemption that applies to laws that "regulate insurance." This Court's precedents make plain that the ERISA saving clause applies only when insurers "are regulated *with respect to their insurance practices*." *Rush Prudential HMO, Inc. v. Moran*, 122 S. Ct. 2151, 2159 (2002) (emphasis added). The laws at issue here regulate HMOs' practice of entering into agreements with providers to provide the medical care promised in the contract of insurance. Thus the question here – the sole question – is whether that practice is an "insurance practice."

A. *Royal Drug* Controls This Case

The Court in *Royal Drug* addressed precisely the same question in the context of the McCarran-Ferguson Act, holding that an insurer's contracts with pharmacies to provide prescription drugs are not an "insurance" practice. Respondent and her amici offer no persuasive ground for distinguishing that holding.

1. Respondent's principal argument compares apples to oranges, contending that the provider contracts at issue in *Royal Drug* were "business decisions," whereas this case involves "state laws" enacted as "patient protection" legislation. Resp. Br. 19-21, 23. The Solicitor General makes the

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[1] Some of respondent's own amici reject her position and contend that AWP laws do not relate to ERISA plans. Am. Coll. Legal Med. Br. 3-15; AMA Br. 7-25. This Court generally does not consider arguments raised only by amici. *See United Parcel Service, Inc. v. Mitchell*, 451 U.S. 56, 60 n.2 (1981); *Bell v. Wolfish*, 441 U.S. 520, 531 n.13 (1979); *Knetsch v. United States*, 364 U.S. 361, 370 (1960). Their arguments are incorrect in any event, for the reasons explained by the court below, the parties, and the Solicitor General. *See also infra* at 18-19.

same mistake. SG Br. 23 ("the subject of the legal inquiry in this case is a *state law*, not private agreements"). The issue here is whether the private business practice the "state laws" regulate is an "insurance" practice. And the practice they regulate is the practice of entering into provider contracts – exactly the same "business decisions" held by this Court *not* to be "insurance" practices in *Royal Drug*.

2. The Solicitor General emphasizes that the provider contracts in *Royal Drug* were not part of a limited network. SG Br. 22. That proffered distinction is wrong as a practical matter, and immaterial in any event. In fact, the provider agreements in *Royal Drug were* part of a network limited in practice, because only a few larger pharmacies could afford to provide drugs on the terms required by the provider agreements. *See* 440 U.S. at 209.[2] The insureds in *Royal Drug* had no right to demand that their insurer make drugs available on "network" terms from "non-network" pharmacies, just as HMO members have no right to demand that HMOs provide care on network terms through non-network providers. From the perspective of the insureds, in other words, there is no practical distinction between the two arrangements.

Nor does the HMO practice of limiting the number of network participants to obtain cost and monitoring advantages reflect any material legal distinction between this case and *Royal Drug*. The *Royal Drug* Court held that provider contracts are not "insurance" because they do not spread risk, because they do not affect the terms of the insurance contract itself, and because they involve entities outside the insurance industry. *See* Petrs. Br. 14-20. Nothing in that analysis suggests that the provider contracts in that case

[2] Indeed, the substantive antitrust law allegation in *Royal Drug* was that the terms of the provider contracts were anticompetitive because they effectively precluded insureds from dealing with certain pharmacies. 440 U.S. at 207.

would somehow have become "insurance" had the insurer specifically limited the number of providers with whom it contracted. To the exact contrary, the *Royal Drug* Court explicitly stated that a network that *is* formally limited to just one provider would no more constitute "insurance" than did the formally non-limited network before the Court. 440 U.S. at 215. It follows that a network limited to more than one provider is not an insurance practice.

3. The Solicitor General also suggests that *Royal Drug*'s holding is categorically inapplicable here because of linguistic differences between § 2(b) of the McCarran-Ferguson Act and the ERISA saving clause. As explained in our opening brief, these differences have *never* affected this Court's reliance on *Royal Drug*'s analysis of "insurance" in ERISA saving clause cases, and they certainly should not in this one, which implicates not just *Royal Drug*'s analytical approach, but its square holding. Petrs. Br. 36-38 & n.17.

The ERISA saving clause saves state laws that "regulate insurance." Section 2(b) of McCarran-Ferguson includes two clauses pertinent here. The first saves state laws "enacted . . . for the purpose of regulating the business of insurance." 15 U.S.C. § 1012(b). The second exempts "the business of insurance" from federal antitrust law to the extent such business is "regulated by State law." *Id.*

a. The Solicitor General first tries to distinguish *Royal Drug* on the ground that while "the ERISA clause broadly saves laws that regulate 'insurance,' the McCarran-Ferguson Act applies in accordance with the more limited term 'business of insurance.'" SG Br. 25-26. In construing the latter term, the Solicitor General claims, this Court has distinguished the "business of insurance" from the "business of insurance companies," holding that "not everything an insurance company does is within the 'business of insurance.'" SG Br. 26. By contrast, the Solicitor General asserts, "the

ERISA saving clause saves the regulation of 'insurance' more generally." *Id.*

That argument is without merit. It is true that this Court has, in several McCarran-Ferguson cases, emphasized that not everything an insurance company does is within the business of insurance. But what is also true – and what the Solicitor General ignores – is that this Court has made precisely the same point in the ERISA saving clause context as well. *See, e.g., Rush Prudential*, 122 S. Ct. at 2159. Indeed, the Court's seminal ERISA saving clause precedent described the fact that a law "fall[s] within the terms of the definition of insurance in the McCarran-Ferguson Act" as "directly relevant" to the saving clause inquiry. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 744 n.21 (1985). Not one of this Court's subsequent saving clause opinions has suggested that the "*business of* insurance" language in § 2(b) constitutes a material limitation that diminishes the relevance of the McCarran-Ferguson/*Royal Drug* analysis of insurance to ERISA saving clause cases.

b. The Solicitor General also seeks to distinguish *Royal Drug* on the ground that that case was based on the "second clause" of § 2(b), which exempts the business of insurance from federal antitrust laws to the extent such business is not regulated by state law. The Solicitor General mistakenly reads *Royal Drug* to be based fundamentally on a "policy favoring a narrow construction of antitrust exemptions." SG Br. 27. While it is true that the *Royal Drug* Court *mentioned* the principle "that exemptions from the antitrust laws are to be narrowly construed," 440 U.S. at 231, the Court did so only at the very end of its opinion, after a full twenty pages analyzing provider contracts under basic insurance principles. The Court plainly did not *rely* on that canon for any aspect of its analysis of what constitutes "insurance." The Court did not suggest, in other words, that it would – or even could – define "insurance" differently or more broadly if the

canon did not apply. To the contrary, the Court's analysis focused specifically on characteristics fundamental to any conception of insurance. Certainly no subsequent ERISA saving clause case has denigrated the relevance of the *Royal Drug* factors on the theory that they are premised on a narrowing interpretive canon inapplicable in the ERISA context.

c. The Solicitor General similarly errs in arguing that only the *first* clause of § 2(b) – not the second clause discussed in *Royal Drug* – is properly relevant to the ERISA saving clause analysis. SG Br. 26-27. The first clause of § 2(b) saves state laws "enacted *for the purpose of* regulating the business of insurance." As the Court explained in *United States Department of Treasury v. Fabe*, 508 U.S. 491 (1993), laws "enacted for the purpose of regulating insurance" necessarily describes more laws than just those that actually do regulate insurance, *id.* at 504. But ERISA does *not* save laws "enacted for the purpose of regulating insurance." Rather, like the *second* clause of § 2(b) construed in *Royal Drug*, ERISA saves only those laws that do, in fact, "regulate insurance." It is thus the second clause of § 2(b) that is the more analogous to the ERISA saving clause.

It is for that reason this Court's ERISA saving clause precedents have always followed *Royal Drug*'s analysis, and have inquired into whether the law at issue actually regulates "insurers *with respect to their insurance practices*." *Rush Prudential*, 122 S. Ct. at 2159 (emphasis added). The Court has never determined that a practice being regulated was *not* "insurance" under any of the *Royal Drug* factors, but then held a law regulating that practice to be within the compass of the ERISA saving clause on the ground that it was enacted "for the purpose" of regulating insurance.[3]

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[3] The Solicitor General's interpretation of footnote 18 in *Royal Drug* confirms his misunderstanding of the relationship between the McCarran-Ferguson Act and the ERISA saving clause. He reads that footnote as "strongly suggesting" that even though provider contracts are not the

4. The Solicitor General's final reason for ignoring *Royal Drug* is that the Court's use of the common sense test in ERISA saving clause cases renders the analysis of "insurance" under ERISA meaningfully different from that in *Royal Drug*. That contention is baseless. In fact, the common sense test does not appear to be any different from the third *Royal Drug* factor, as this Court's precedents reveal, *see* Petrs. Br. 35 n.15 (citing cases), and as the submissions of both the Solicitor General and respondent confirm, SG Br. 21 (AWP law satisfies third factor "for essentially the same reasons that the AWP law regulates insurance as a matter of common sense"); Resp. Br. 21. If the common sense test in this respect simply reflects a subset of the *Royal Drug* analysis, the results of the two tests are likely to be the same in

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"business of insurance" under the second clause, they could be regulated by state law under the first clause, which the Solicitor General takes to mean that the first clause is more like the ERISA saving clause. SG Br. 27. What the footnote actually says is that the "primary purpose" of the McCarran-Ferguson Act was to "assure that the States are free to regulate insurance companies without fear of Commerce Clause attack." 440 U.S. at 218 n.18. That goal was accomplished *not* by the first clause of § 2(b), on which the Solicitor General relies, but by § 2(a), which provides: "The business of insurance . . . shall be subject to the laws of the several States which relate to the regulation or taxation of such business." 15 U.S.C. § 1012(a); *see Metropolitan Life*, 471 U.S. at 744 n.21. In addition to finding the definition of the "business of insurance" set forth in *Royal Drug* "directly relevant" to the ERISA saving clause, the leading ERISA saving clause precedent equates the saving clause not with the broader, subjective "enacted for the purpose of" language in the first clause of § 2(b), but with the objective language of § 2(a), which parallels the objective second clause of § 2(b). *See Metropolitan Life*, 471 U.S. at 744 n.21. The Solicitor General also ignores the remainder of footnote 18 in *Royal Drug*, which goes on to observe that the second clause of § 2(b) does not address "the business of insurance companies," but the much narrower "business of insurance." *Id.* (internal quotation marks omitted). Likewise, this Court's ERISA saving clause jurisprudence recognizes that the saving clause does *not* save laws that regulate "insurance companies," it only saves laws that regulate "insurance." *See Rush Prudential*, 122 S. Ct. at 2159.

most cases (unless examination of the other *Royal Drug* factors casts sufficient doubt on the results of the common sense test).

The Solicitor General's related argument that the *Royal Drug* factors can *never* be dispositive, SG Br. 24, is equally incorrect. On that view, the common sense test would *always* be dispositive, and the *Royal Drug* factors would serve no purpose whatsoever. That cannot be true. In fact, it is possible for either prong of the saving clause inquiry to be dispositive in the right circumstances. As the Court's precedents describe the *Royal Drug* factors, they are to serve as an objective legal "check" or "test" of the results of the more subjective, intuitional common sense inquiry. As just discussed, in the run of cases the inquiries will be the same, and the *Royal Drug* analysis will only appear secondary or subordinate. But the common sense test can also be "primary" in the more substantive sense that even if one of the *Royal Drug* factors is missing in a given case – such that a practice might not fit the *Royal Drug* definition of "insurance" standing alone – a common sense impression of the practice as "insurance" could prevail, so long as one or two of the other *Royal Drug* factors confirms that intuition to some extent. If the *Royal Drug* factors are to serve as any true "check" or "test" of the common sense inquiry, however, they must prevail when they *all* establish that a given practice is not "insurance." So it is here: this Court has already applied the factors to hold specifically that an insurer's contracts with care providers are not an "insurance" practice. That holding should control.

Our point, of course, is not that *Royal Drug* leads to a conclusion about an HMO's provider contracts that differs from the results of the common sense inquiry. Our point is that *even if* provider contracts appeared to be an insurance practice as a matter of common sense, that impression would be refuted once "tested" or "checked" by *Royal Drug*. That

is why the holding of *Royal Drug* fully suffices, on its own terms, to answer the dispositive legal question in this case. Unless *Royal Drug* is overruled – and no party here contends that it should be – its analytical premise compels the conclusion that an HMO's contracts with providers are not the practice of "insurance," and thus that laws regulating that practice are not laws that regulate "insurance."

B. The ERISA Saving Clause Inquiry Confirms That AWP Laws Do Not Regulate A Practice That Is "Insurance"

In any event, AWP laws do not "regulate insurance" as a matter of common sense. The factors set forth in *Royal Drug* confirm that conclusion, not just in light of *Royal Drug*'s own holding, but also in light of the way the factors have been applied in the Court's ERISA saving clause cases.

1. AWP laws do not "regulate insurance" from a common sense viewpoint. The contracts they directly regulate are contracts between insurers and non-insurers. As respondent's amici the American Medical Association et al. explain: "The Kentucky statute *directly* and *primarily* regulates the relationship between the insurer and the health care service provider." AMA Br. 25 (emphasis added). Neither respondent nor any of her amici contend that the insurer-provider contract itself involves any risk-spreading – the "primary element[] of an insurance contract," *Rush Prudential*, 122 S. Ct. at 2159 – or in any other way constitutes an insurance contract. AWP laws thus do not "home in" on insurance contracts or the insurance industry, *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 368 (1999), but on non-insurance contracts involving non-insurers.

The Solicitor General denies this, arguing that "the specific obligation of the AWP law falls only upon health insurers." SG Br. 13 (internal quotation marks omitted). But that is to acknowledge only half of the necessary legal effect of the law: by imposing an explicit regulatory prohibition upon

insurers, an AWP law creates a formal legal right *in providers* – i.e., the right to join any network whose terms they are willing to accept.[4]

In any event, the fact that the state acts explicitly only on the insurer half of the transaction is merely a coincidence of the state's choice to codify the regulation in the state's insurance code. The state could just as easily have elected to directly bar providers from entering into limited network contracts with insurers, and codified that prohibition in the statutory provisions regulating health-care providers. Indeed, respondent herself refers to the laws repeatedly as "patient protection" legislation. Resp. Br. 3, 15, 19. Under this Court's precedents, the mere fact that the state elected to *label* its AWP laws "insurance laws" (Resp. Br. 13-14; SG Br. 14) simply does not determine their character as laws that regulate an "insurance *practice*," especially where the laws directly regulate a practice that necessarily includes non-insurer entities.[5] *See Rush Prudential*, 122 S. Ct. at 2162 n.5. In this respect AWP laws cannot be accurately described as targeted at entities and transactions solely, or even primarily, within the insurance industry.[6]

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[4] By contrast, such laws create no legal rights in insureds. *See infra* at 12-14.

[5] Respondent's amici Council of State Governments et al. suggest that AWP laws are "grounded in policy concerns specific to the insurance industry." Council State Gov. Br. 13. That is incorrect. Respondent herself describes them specifically as a form of health care legislation. In fact, AWP laws historically have been motivated more by concerns about provider market share than by concerns about *either* patient care *or* the adequacy or extent of insurance coverage. Comm. Health Ptnrs. Br. 2-9; American Ass'n Health Plans et al. Br. 13-16.

[6] The Solicitor General argues that if the fact that AWP laws regulate HMOs' contracts with providers "were sufficient to remove a state law from the scope of ERISA's saving clause," then a number of state laws purportedly regulating insurers' arrangements with providers "would be in danger of preemption." SG Br. 13-14; *see* Resp. Br. 15 n.12. But the

Respondent and her amici also contend that AWP laws regulate insurance as a matter of common sense because they "specifically regulate the terms of the insurance contract." Resp. Br. 17; *see* SG Br. 15 (AWP laws "directly affect the terms of the relationship between insurer and insured"). That contention is demonstrably incorrect. Even the majority below found it "admittedly true that the AWP laws do not change the substantive terms of the insurance coverage." Pet. App. 36a. The terms of the kind of insurance contract at issue here can be found in the exemplary Certificate of Coverage set forth in the Joint Appendix. In support of their contentions that AWP laws "specifically" and "directly" alter the terms of HMO policies, neither respondent nor the So-

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fact that AWP laws regulate the insurer-provider contract is not, in and of itself, necessarily "sufficient" to establish that the law is outside the saving clause. If the regulation of the insurer-provider contract has a material effect on the legal rights of insureds under their insurance policies, then the regulation would be tantamount to laws that mandate benefits or otherwise alter the terms of the insurance contract itself. *See, e.g.*, *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999) (law affecting insurers' rights to deny claims not preempted); *Metropolitan Life*, *supra* (law requiring minimum mental health benefits not preempted). Many of the provisions cited by the Solicitor General and the respondent arguably constitute regulations that materially alter the legal rights of insureds. By contrast, as we have explained, AWP laws do *not* materially alter the legal rights of HMO members under their HMO policies. Other laws cited by the Solicitor General and the respondent – including claim forms regulations and ministerial notification and disclosure requirements – have only a *de minimis* effect on ERISA plans and therefore do not "relate to" such plans at all. *See Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 100 n.21 (1983) ("Some state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan."). Finally, to the extent that there are other provisions with more direct impacts on ERISA plans but *not* on the benefits such plans provide – such as laws governing the submission of claims by providers – such provisions likely are *not* laws that regulate insurance and would thus be preempted. Neither the Solicitor General nor respondent identifies any problematic policy implications that would result from the routine application of saving clause principles to such laws.

licitor General identifies a single item in that Certificate that is "specifically" or "directly" altered by the AWP laws.

Instead respondent and her amici argue more generally that AWP laws allow "greater access to care and, thus, provide a richer benefit for the insured." Resp. Br. 17. As the Solicitor General puts the point, AWP laws require HMOs to provide coverage for services from any provider willing to comply with the terms of the network contract, which is coverage they would not otherwise be required to provide. SG Br. 16. Those arguments fundamentally misconceive the nature of the coverage and benefits HMO policies provide.

To begin with, it is flatly incorrect to argue that AWP laws give an HMO member "a right to select a provider" outside the HMO's network. Council State Gov. Br. 24. They do not. AWP laws do not affect *in any way* the right of HMOs to require that members seek care only from providers who are part of the HMO network. Nor do AWP laws affect *in any way* the right of HMOs to set the terms of the provider networks. What AWP laws do is to create a right in providers – entities wholly outside the insurer-insured relationship, *see supra* at 10-11 – to join a network if they so decide. The only "right" or "benefit" AWP laws confer on an HMO member is the opportunity to try to "convince" his or her provider to join a network. SG Br. 15. The decision whether to do so remains entirely in the hands of the provider. Thus, under no construction do AWP laws provide "a legal right to the insured, enforceable against the HMO." *Rush Prudential*, 122 S. Ct. at 2164. And neither respondent nor the Solicitor General point to any evidence demonstrating that, in fact, providers often do join networks at the behest of individual patients.

Absent AWP laws, HMO members already have the opportunity the try to persuade their own providers to try to join a network. The provider will not even try to do so if the terms of the network contract are unacceptable. AWP laws

do not affect that decision at all, because AWP laws do not require HMOs to alter the substantive terms of their network contracts. AWP laws only require HMOs to accept providers who want to join but who would be excluded by a network size limitation. From the perspective of the HMO member, then, AWP laws mean only that a member has a somewhat increased likelihood of successfully persuading his or her provider to join a network.[7] That the HMO member may applaud whatever marginal increase AWP laws have on the likelihood of getting his or her provider of choice into a given network simply does not mean the member has any different legal rights or benefits under the contractual insurance relationship than he or she did absent the AWP laws. With or without AWP laws, a subscriber has rights under a typical HMO policy to necessary and appropriate care for covered medical needs from network providers. AWP laws do not alter any of those rights in the slightest.

Other than HMOs and the ERISA plans that use them, the only parties whose legal rights are altered by AWP laws are providers. The fact that AWP laws regulate the latter non-insurance entities, and their non-insurance contracts with HMOs, with no material impact on insurance contracts or the rights of insureds, demonstrates that AWP laws do not regulate "insurance" as a matter of common sense.

[7] Contrary to the Solicitor General's assertion, SG Br. 20, we do not contend that AWP laws pose a risk to HMOs because provider networks will necessarily expand significantly as a result. The larger problem is uncertainty: absent foreknowledge of the size of the network, a provider considering whether to join will not be able to predict reliably the volume of patient business membership would provide, and thus will be less likely to agree to a discounted fee for services, eviscerating one of the fundamental purposes of managed care arrangements. *See* Comm. Health Ptnrs. Br. 7, 8 & n.3; Soc'y for Human Res. Br. 8.

2. The same result obtains when HMO provider contracts are analyzed under the *Royal Drug* factors – as *Royal Drug* itself held.

a. *Royal Drug* held that provider contracts do not spread risk. Respondent and her amici do not contend otherwise. Instead they argue that by directly regulating non-insurance provider contracts, AWP laws *indirectly* alter the risk transferred by HMO policies. AWP laws affect risk-spreading, the argument goes, by allowing subscribers who think they will want to see a non-network provider in the event of medical need to avoid assuming the risk of having to pay for care from such a provider. Resp. Br. 18-19; SG Br. 19.

As explained in our opening brief and discussed further above, that analysis mischaracterizes the risk HMO policies address. Insurance of any kind is not typically purchased to guarantee that one will be able to receive care from a particular provider. Insurance, including HMO-style coverage, exists to transfer the risk of needing to pay for care at all. Petrs. Br. 22-26. HMOs thus do not transfer the risk of needing to pay for care only from a limited number of network providers; the limitation on providers simply results from the HMO's business decision about how to satisfy its general obligation to provide care. Respondent's analysis confuses that business decision with the fundamental risk an HMO assumes. The fact that a member may care how an HMO decides to fulfill its policy obligations simply does not determine or affect the nature of the risk transfer those obligations reflect.[8]

What is more, even if it made sense to imagine that insurance exists to shift the risk that an insured will want to

[8] For the same reasons, the Solicitor General is mistaken when he describes the "covered risk" as the risk of needing care *from network providers*. SG Br. 19. The only risk "covered" is the risk of needing care at all.

seek care from a particular provider in the event of medical need, AWP laws do not force a transfer of that risk to the HMO. As we have explained, AWP laws do not confer on an HMO member the right to seek care from any particular provider and then demand satisfaction from the HMO. At best they give the member a marginally improved chance of convincing his or her provider of choice to join the network on the HMO's terms. Even under respondent's conception, the limited risk assumed by the HMO – the risk of needing care from the particular providers who decide to become members of the HMO's network – remains the same. The only difference is the price the HMO must pay to provide that care.[9]

b. *Royal Drug* also held that provider contracts are not integral to the insurer-insured bargain. More recently, this Court has characterized a law as affecting a practice "integral" to this bargain when the law provides "a legal right to the insured, enforceable against the HMO." *Rush Prudential*, 122 S. Ct. at 2164. That simply is not true of AWP laws, as we have demonstrated. *See supra* at 12-14.

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[9] Similarly, AWP laws plainly do not remove the "condition" that treatment must be provided only by a provider who is part of the HMO's network. SG Br. 19. AWP laws may, or may not, have the effect of expanding the number of providers in the network, but they in no way confer a right on the member to demand payment for treatment from any provider not already in the HMO's network. It is equally incorrect to say that AWP laws "regulate the performance of the insurance contract . . . by specifying which providers' services may be furnished in kind in fulfillment of the HMO's insurance obligation." SG Br. 19 n.3. AWP laws do *not* specify which providers' services may be furnished to satisfy the care obligation; the *only* services that may be used are those of providers who have decided to accept the terms of membership in the HMO's network. A member may not seek care from any provider of his or her choosing, and then present the bill for payment with a representation that the provider is willing to join the network. Rather, the provider must first agree to abide by all the contractual terms of the network, a decision that can be made only by the provider.

Respondent's only argument that provider contracts are "integral" to the insurer-insured bargain relies on a recently enacted provision of Kentucky law requiring HMOs to provide the list of network providers along with the Certificate of Coverage. Resp. Br. 20. But obviously Kentucky cannot by this device turn a practice that is otherwise not an insurance practice under federal saving clause law into an insurance practice. And even if it is true as a "function[al]" matter that an HMO must maintain and provide to members a list of network providers, the same could be said of a host of business practices necessary to ensure that the HMO satisfies its policy obligations. As this Court has explained, "in that sense, every business decision made by an insurance company has some impact on its reliability, its ratemaking, and its status as a reliable insurer. . . . Such a result would be plainly contrary to the statutory language, which exempts the 'business of insurance' and not the 'business of insurance companies.'" *Royal Drug*, 440 U.S. at 216-17. Similarly, the ERISA saving clause saves laws that "regulate *insurance*," not laws that "regulate the business of insurers," and certainly not "laws that regulate the business of HMOs."

c. *Royal Drug* finally held that provider contracts are not part of the business of insurance because they directly involve entities outside the insurance industry. This third *Royal Drug* factor does not ask whether a law is one of "broad or general application that happens to include health insurers with in its reach," as the Solicitor General tries to characterize it. SG Br. 21. This Court's ERISA precedents make clear that this factor requires the targets of the law to be "limited to entities within the insurance industry," *Rush Prudential*, 122 S. Ct. at 2164 – "*i.e.*, to insurers and entities acting as insurers," SG Br. 21. Under no conception are AWP laws limited only to "insurers and entities acting as insurers." As discussed above, the only conduct AWP laws directly regulate is the conduct of insurers *and providers*,

and the only contract they directly regulate is the non-insurance contract between those entities.

C. A Finding That AWP Laws Are Outside The Saving Clause Does Not Mean That AWP Laws Do Not "Relate To" ERISA Plans

The Solicitor General concludes his argument by contending that, if AWP laws do not regulate "insurance" under petitioners' theory, then they do not "relate to" ERISA plans at all. According to the Solicitor General:

> Petitioners cannot have it both ways, arguing that the Kentucky AWP law is both so closely connected to an ERISA plan because of its impact on plan benefits that it "relates to" ERISA plans . . . *and* that its operation is so distant from the relationship between an insurer and ERISA plans and their insured members that it does not even constitute a law that "regulates insurance."

SG Br. 29-30.

While the Solicitor General describes with general accuracy our view as to why AWP laws do not "regulate insurance," he misapprehends the reason such laws "relate to" ERISA plans. Our position is clear: AWP laws do *not* have an impact on "plan benefits." They do, however, "bear indirectly but substantially on all insured benefit *plans*," *Rush Prudential*, 122 S. Ct. at 2159 (emphasis added), because they directly affect "employee benefit *structures* or their *administration*," *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995) (emphasis added).

To say that a law affects the "structures" or "administration" of ERISA plans is not necessarily to say that the law affects the terms of the plan benefits themselves. By affecting the HMO's ability to control the network of providers who provide health benefits, AWP laws indirectly but substantially affect the way in which ERISA plans that use

HMOs are able to structure and administer the provision of health benefits. Health benefits that previously were provided through "closed panel" structures now must be provided through "open panel" structures. But, for the reasons we have explained, this important change in the structure and administration of ERISA plans that use HMOs does not alter, or even affect, the health insurance benefits the ERISA plans actually provide. In short, AWP laws "relate to" ERISA plans, but they do not regulate the "insurance" such plans provide.

CONCLUSION

For the foregoing reasons, and for the reasons set forth in our opening brief, the judgment of the court of appeals should be reversed.

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KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., ET AL., PETITIONERS

v.

JANIE A. MILLER, COMMISSIONER, KENTUCKY DEPARTMENT OF INSURANCE

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING RESPONDENT

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QUESTION PRESENTED

Whether Kentucky's "any willing provider" law, which requires each insurer (including each health maintenance organization) in the State to make available to its insureds the services of any medical provider in its geographical region that agrees to the terms and conditions offered by the insurer, is saved from preemption as a law that "regulates insurance" under Section 514(b)(2)(A) of the Employee Retirement Security Act of 1974, 29 U.S.C. 1144(b)(2)(A).

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BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING RESPONDENT

INTEREST OF THE UNITED STATES

The Secretary of Labor has primary authority for enforcing and administering Title I of the Employee Retirement Income Security Act of 1974 (ERISA) 29 U.S.C. 1001 *et seq.* See 29 U.S.C. 1002(13), 1136(b). The United States filed an amicus brief at the petition stage in response to this Court's order inviting the Solicitor General to express the views of the United States.

STATEMENT

1. The "any willing provider" (AWP) section of Kentucky's Insurance Code provides:

> A health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer, including the Kentucky state Medicaid program and Medicaid partnerships.

Ky. Rev. Stat. Ann. § 304.17A-270 (Michie 2001). Under the Insurance Code, the insurer must disclose in writing to

insureds "that if the provider meets the insurer's enrollment criteria and is willing to meet the terms and conditions for participation, the provider has the right to become a provider for the insurer." *Id.* § 304.17A-505(1)(k).

Other provisions of Kentucky's Insurance Code extensively address the relationship between insurers and health-care providers. Insurers must "establish relevant, objective standards" for providers to participate in their networks, and they must not "use criteria that would allow an insurer to avoid high-risk populations." Ky. Rev. Stat. Ann. § 304.17A-525 (Michie 2001). Insurers must pay claims timely and correctly submitted by providers and publicize the information needed to submit a claim. *Id.* § 304.17A-702. Contracts between insurers and providers must include a number of mandatory clauses, including a "hold harmless" clause that precludes providers from seeking reimbursement from their patients, and a "continuity of care" clause that requires the provider to continue providing care even after termination of the contract under certain conditions. *Id.* § 304.17A-527(1). In addition, a "managed care plan may not contract with a health care provider to limit the provider's disclosure to an enrollee * * * of any information relating to the enrollee's medical condition or treatment options." *Id.* § 304.17A-530(1). See *id.* § 304.17A-515(1) (requiring managed care plans to "arrange for a sufficient number and type of primary care providers and specialists"); *id.* § 304.17A-150 (insurer may not require provider to participate in all of insurer's plans if provider wants only to participate in one).

The Insurance Code defines "insurer" for these purposes as

> any insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky.

Id. § 304.17A-005(23).

2. Petitioners are three health maintenance organizations (HMOs) and an association of HMOs that operate in Kentucky. Pet. Br. ii. As it applies to HMOs, the effect of the AWP provision of Kentucky's Insurance Code is to require an HMO to open its provider network to any qualified physician in the covered geographic area who is willing to abide by the HMO's terms and conditions. The purpose of such AWP laws is to foster patients' freedom to receive medical care from providers of their choice. See Kentucky Br. in Opp. 2 ("In drafting the AWP statutes, the Kentucky General Assembly's clear focus was to regulate insurance and to provide additional benefits to the consumers of Kentucky, many of whom were limited to one choice of insurer in their county or geographic area.").

The question presented in this case is whether ERISA preempts the Kentucky AWP law. The issue arises because ERISA governs employer-provided health plans, the great majority of which are insured or administered by HMOs. Sara Rosenbaum & Brian Kamoie, *Managed Care and Public Health: Conflict and Collaboration*, 30 J.L. Med. & Ethics 191, 192 (2002) ("As of 2000, more than 90 percent of all persons with employer-based health insurance coverage were enrolled in some form of managed care."). Three related components of ERISA's express preemption provision are relevant. First, ERISA's general preemption provision, Section 514(a), 29 U.S.C. 1144(a), states that the provisions of ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." Second, Section 514(a) is "substantially" and "broadly" qualified, *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 733 (1985), by a saving clause, which provides that "nothing in this subchapter shall be construed to exempt or

relieve any person from any law of any State *which regulates insurance*, banking, or securities." ERISA Section 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A) (emphasis added). Third, ERISA's "deemer" clause, Section 514(b)(2)(B), 29 U.S.C. 1144(b)(2)(B), which qualifies the insurance saving clause, provides that "[n]either an employee benefit plan * * * nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer * * * for purposes of any law of any State purporting to regulate insurance companies, [and] insurance contracts."

3. Petitioners filed suit to enjoin respondent from enforcing Kentucky's AWP law, contending that it is preempted by ERISA. Pet. App. 64a-65a. The district court held that, although the law "relate[s] to" ERISA plans, it "regulates insurance" and is therefore saved from preemption under the saving clause. *Id.* at 78a-83a.

4. A divided panel of the Sixth Circuit affirmed. Pet. App. 1a-38a. The court unanimously ruled that Kentucky's AWP law "relate[s] to" employee benefit plans under 29 U.S.C. 1144(a), because it has both a reference to and a connection with ERISA plans. The court concluded that, because the AWP law in terms applies to a self-insurer that is "not exempt from state regulation by ERISA," see Ky. Rev. Stat. Ann. § 304.17A-005(23) (Michie 2001), it refers to ERISA plans. See Pet. App. 14a. The court further held that such AWP laws have a connection with ERISA plans because they "affect the benefits available by increasing the potential providers, [and] they directly affect the administration of the plans." *Id.* at 19a.

Like the district court, however, the panel majority ruled that the AWP law is saved from preemption as a law that "regulates insurance." The court first found (Pet. App. 22a-24a) that the AWP law is specifically directed at the insurance industry, thus satisfying the "common-sense" test that this Court has set forth in applying ERISA's insurance saving clause. Indeed, the court found the common-sense

test "clearly" satisfied because the AWP law increases benefits by giving enrollees more freedom to choose and is part of "a comprehensive subtitle of Kentucky's insurance code regulating health benefit plans." Pet. App. 30a.

Following this Court's precedents, the court also considered the three factors utilized in determining whether a particular practice constitutes the "business of insurance" for purposes of the McCarran-Ferguson Act, 15 U.S.C. 1012(b). First, the court concluded that the AWP law "spreads the cost component of the policyholder's risk among all insureds, instead of requiring the policyholder to shoulder all or part of the cost when seeking care or treatment from an excluded doctor or hospital of his or her choice." Pet. App. 31a. Second, the court found that the AWP law "directly impact[s] the insurer-insured relationship because [it] * * * expand[s] covered treatment from a closed pool of providers to an open pool of providers." *Id.* at 36a. Third, the court reiterated that the AWP law is directed at insurance. *Id.* at 36a-37a.

Judge Kennedy dissented from the court's holding that the AWP law "regulates insurance" and is therefore saved from preemption. Pet. App. 39a-63a.

SUMMARY OF ARGUMENT

I. Kentucky's AWP law "relate[s] to" ERISA plans within the meaning of ERISA's preemption clause, 29 U.S.C. 1144(a), "by requiring them to [maintain open-panel provider networks] if they purchase medical coverage from any of the common types of health care organizations covered by the state law's definition of [health insurer]." *Rush Prudential HMO, Inc.* v. *Moran*, 122 S. Ct. 2151, 2159 (2002).

II. The Kentucky law, however, is saved from preemption because it is a law that "regulates insurance" within the meaning of ERISA's insurance saving clause, 29 U.S.C. 1144(b)(2)(A). The law regulates insurance as a matter of "common sense" because it is directed at insurers, including HMOs. *Rush*, 122 S. Ct. at 2159-2160. The relevant provi-

sion twice refers to "health insurer[s]" as the object of state regulation, and it is codified in Kentucky's Insurance Code, along with many other regulations of insurers. Furthermore, the AWP law's mandate of open-panel provider networks fundamentally affects the insurer's underlying insurance promise to the insured: it prohibits insurance arrangements in which the insurer essentially agrees to insure against medical costs only if incurred with the insurer's choice of provider, and it instead requires arrangements in which the insurer agrees to insure against medical costs if incurred with any provider who is willing to accept the insurer's fees and qualification standards.

If Kentucky's AWP law is not insurance regulation from a common sense view, the ability of Kentucky (and many other States) to enforce any of the large variety of other laws that regulate the relationship between health insurers of all types and health-care providers will similarly be threatened by ERISA preemption. Petitioners' arguments are thus contrary to this Court's precedents, which have emphasized that ERISA was intended to preserve state law in areas of traditional state regulation such as insurance and health care.

The common sense conclusion that Kentucky's AWP law "regulates insurance" is confirmed by a consideration of the three factors that have been used to determine what constitutes the "business of insurance" under the McCarran-Ferguson Act. First, the AWP law concerns the allocation and spreading of risks in that it addresses the performance of the insurance contract, and without performance "there is no risk transfer at all." *Department of Treasury* v. *Fabe*, 508 U.S. 491, 503-504 (1993). Second, the law affects an integral part of the policy relationship, because it substantially affects the scope of the coverage offered by the insurer. Third, it is limited to entities within the insurance industry.

III. Contrary to petitioners' arguments (Br. 14-27), *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1979), does not control this case. *Royal Drug* involved an insurer's

agreements with pharmacies to limit its costs, a matter with which the insureds were basically unconcerned. The Kentucky AWP law, by contrast, imposes an obligation only on insurers—to accept any willing and qualified provider into their networks—and it does so in order to affect the very structure of the benefit that will be provided to the insured.

More fundamentally, petitioners' argument is based on the erroneous proposition that the analysis in *Royal Drug* controls the analysis of whether a state law "regulates insurance" under ERISA. This Court has never held that the McCarran-Ferguson factors drawn from *Royal Drug* are dispositive in the ERISA context. Instead, as the primary test under ERISA, the Court has set forth a common-sense inquiry, with the McCarran-Ferguson factors used only as relevant guideposts. Furthermore, *Royal Drug* itself involved a claim of exemption from the antitrust laws under the second clause of Section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. 1012(b), which exempts the "business of insurance" from the federal antitrust laws. The Court explained both in *Royal Drug* and in *Fabe* that its analysis in *Royal Drug* was influenced by the well-settled rule that exemptions from the antitrust laws must be narrowly construed. The ERISA analysis, however, is driven by the quite different policy of preserving state authority in areas of traditional state regulation (such as insurance and health care) unless Congress's intent to preempt such authority is clear.

ARGUMENT

I. THE KENTUCKY ANY WILLING PROVIDER LAW "RELATES TO" ERISA PLANS BECAUSE IT HAS A CONNECTION WITH SUCH PLANS

Under Section 514(a) of ERISA, 29 U.S.C. 1144(a), the provisions of ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." Section 514(a) "indicates Congress's intent to establish the regulation of * * * [ERISA] plans as exclu-

sively a federal concern." *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 656 (1995) (internal quotation marks omitted). Section 514(a) is "clearly expansive" in its preemptive sweep. *Egelhoff* v. *Egelhoff*, 532 U.S. 141, 146 (2001). In general, a state law "relate[s] to" an ERISA plan "if it has a connection with or reference to such a plan." *Id.* at 532 U.S. at 147 (quoting *Shaw* v. *Delta Air Lines*, 463 U.S. 85, 97 (1983)).

The court of appeals erred in holding that the Kentucky AWP law makes a prohibited "reference to" ERISA plans. By its terms, the AWP law applies to any "insurer," including any "self-insurer or multiple employer welfare arrangement *not exempt from state regulation by ERISA*." Ky. Rev. Stat. Ann. § 304.17A-005(23) (Michie 2001) (emphasis added). That reference to the ERISA *statute* neither singles ERISA *plans* out for different treatment as a matter of state law, *Mackey* v. *Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 830 (1988), nor is dependent on the existence of such plans for its operation, *District of Columbia* v. *Greater Washington Bd. of Trade*, 506 U.S. 125, 130-131 (1992); see *California Div. of Labor Standards Enforcement* v. *Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997). Rather, the AWP law's reference to ERISA simply gives effect to the restrictions imposed as a matter of federal law by the "deemer clause" of ERISA, Section 514(b)(2)(B), 29 U.S.C. 1144(b)(2)(B), which prevents the States from regulating self-insured ERISA plans under the guise of regulating insurance. *FMC Corp.* v. *Holliday*, 498 U.S. 52, 61 (1990). Such a reference to ERISA is essentially surplusage, because ERISA's deemer clause would limit the state law's applicability to self-insured ERISA plans in any event. See *Rush Prudential HMO, Inc.* v. *Moran*, 122 S. Ct. 2151, 2162 (2002); *FMC Corp.*, 498 U.S. at 61, 62. It would be perverse —and an affront to federalism—to conclude that a State's express acknowledgment of ERISA's preemptive force would

require preemption of the entire state law that contains that acknowledgment.

The Kentucky AWP law does, however, have a "connection with" ERISA plans sufficient to conclude that it "relates to" such plans within the meaning of Section 514(a). In *Rush*, the Court held it to be "beyond serious dispute" that a state law requiring an HMO to provide independent review of disputes between a patient and the HMO "relates to" ERISA plans because the law forced HMOs to submit to "an extra layer of review for certain benefit denials" under the ERISA plans the HMOs insured. 122 S. Ct. at 2159. The Kentucky AWP law does not have the same sort of direct impact on the actual administration of claims under ERISA plans. And, to be sure, the AWP law does have an effect on providers, who are one step further removed from ERISA plans than are the insurers themselves. But the AWP law *also* has a substantial effect on the coverage that is offered to individuals who are insured under insurance purchased by ERISA plans. The latter effect is sufficient to render the AWP law one that is connected with, and therefore "relates to," ERISA plans.

The AWP law requires HMOs and other insurers to offer open-panel provider networks (*i.e.*, those in which the insurer must include in its roster of available providers any qualified physician willing to abide by its rules), rather than closed-panel networks (*i.e.*, those in which the insurer may limit the providers as it wishes), to all who purchase their policies, including ERISA plans. The consequence is to preclude HMOs from artificially limiting the number of available providers and thus to broaden the range of providers whose services will be covered by insurance under the plan. The impact of the AWP law is not merely an incidental economic one, as in *Travelers*, 514 U.S. at 658-662; *Dillingham*, 519 U.S. at 328-334; *Mackey*, 486 U.S. at 831-836; and *De Buono* v. *NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 815-816 (1997). Instead, whether viewed from the perspec-

tive of the insured, whose range of options under the insurance policy is broadened, or the insurer, which is precluded from limiting its network of providers, the AWP law "mandate[s] employee benefit structures or their administration." *Travelers*, 514 U.S. at 658; see *Rush*, 122 S. Ct. at 2159. It therefore is most analogous to mandated-benefit laws, which this Court has found relate to ERISA plans. Compare *Metropolitan Life*, 471 U.S. at 739 (assuming that law requiring minimum mental health benefits relates to ERISA plans); *Shaw*, 463 U.S. at 97 (law requiring pregnancy benefits relates to ERISA plans). Thus, like the Illinois law in *Rush*, Kentucky's AWP law has a "connection with" ERISA plans because it "bears 'indirectly but substantially on all insured benefit plans' * * * [that] purchase medical coverage from any of the common types of health care organizations covered by the state law's definition of [health insurer]." *Rush*, 122 S. Ct. at 2159 (quoting *Metropolitan Life*, 471 U.S. at 739).

II. KENTUCKY'S AWP LAW "REGULATES INSURANCE" WITHIN THE MEANING OF ERISA'S INSURANCE SAVING CLAUSE

ERISA's saving clause, Section 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A), "reclaims [to the States] a substantial amount of ground" that the basic "relates to" preemption provision in Section 514(a) otherwise would take away. *Rush*, 122 S. Ct. at 2158. The saving clause provides that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. 1144(b)(2)(A). By saving state laws that "regulate[] insurance," Section 514(b)(2)(A) "leaves room for complementary or dual federal and state regulation," *John Hancock Mut. Life Ins. Co.* v. *Harris*, 510 U.S. 86, 98 (1993), and preserves the States' traditional role in insurance regulation. Indeed, construction of the insurance saving clause is informed by the bedrock principle that

"the historic police powers of the States were not meant to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *Rush*, 122 S. Ct. at 2159 (quoting *Travelers*, 514 U.S. at 655); *De Buono*, 520 U.S. at 813 n.8 (same); *Metropolitan Life*, 471 U.S. at 740 (saving clause "broadly" preserves State's lawmaking powers).

A. As A Matter Of "Common Sense," Kentucky's AWP Law Regulates Insurance

To determine whether a state law "regulates insurance" and thus is saved from preemption under ERISA, the Court first undertakes a "'common-sense view of the matter' under which a 'law must not just have an impact on the insurance industry, but must be specifically directed toward that industry.'" *Rush*, 122 S. Ct. at 2159 (quoting *Metropolitan Life*, 471 U.S. at 740, and *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 50 (1987)); accord *UNUM Life Ins. Co. of Am.* v. *Ward*, 526 U.S. 358, 367-368 (1999). A state tort or contract law of general applicability that includes the insurance industry within its reach, but is not specifically directed at it, does not "regulate[] insurance" and therefore is not within the saving clause. *Pilot Life*, 481 U.S. at 50, 57. A state law, however, that "homes in on the insurance industry and does 'not just have an impact on [that] industry'" satisfies the common-sense inquiry. *UNUM*, 526 U.S. at 368 (quoting *Pilot Life*, 481 U.S. at 50).

1. The AWP law satisfies the common-sense inquiry because it is specifically directed at the insurance industry. By its terms, the law applies to "health insurer[s]." Pet. App. 89a. The law defines insurers to include not only traditional health insurers, but also entities that take more innovative approaches to insurance and the provision of health care, such as a "health maintenance organization" and a "provider-sponsored integrated health delivery network." Ky. Rev. Stat. Ann. § 304.17A-005(23) (Michie 2001); see *Rush*, 122 S. Ct. at 2163. Petitioners concede that HMO-style organiza-

tions are "insurers." Pet. Br. 30; see *Pegram* v. *Herdrich*, 530 U.S. 211, 218-219 (2000); accord *Rush*, 122 S. Ct. at 2160. While nontraditional insurance entities such as HMOs may directly provide health care, they still function as insurers, and the insurance saving clause applies. *Rush*, 122 S. Ct. at 2160, 2163.

Petitioners contend (Br. 31 n.14) that the Kentucky AWP law is not specifically directed at the insurance industry because it applies to *self*-insured government and church medical benefit plans, which are not ERISA plans, see 29 U.S.C. 1003(b). A State, however, may reasonably conclude that "a party who has not purchased insurance, effectively act[s] as its own insurer" in a particular context, and may therefore regulate that self-insuring entity as part of the State's regulation of insurance. Pet. App. 24a; see *General Elec. Co.* v. *Gilbert*, 429 U.S. 125, 138 n.16 (1976) ("That General Electric self-insures does not change the fact that it is, in effect, acting as an insurer."). Indeed, ERISA's deemer clause, 29 U.S.C. 1144(b)(2)(B), necessarily presumes that self-insured entities are generally subject to state insurance laws; otherwise, "it would have been unnecessary for the deemer clause explicitly to exempt such laws from the [insurance] saving clause," which, after all, saves only state laws that "regulate[] insurance" in the first place. *Metropolitan Life*, 471 U.S. at 741. In *Metropolitan Life*, this Court held that a state mandated-benefits law regulated "insurance" within the meaning of the saving clause, even though it included self-insured plans among the insurers within its scope. See *id.* at 735-736 n.14, 740-747. The same conclusion follows here.[1]

[1] Petitioners also rely (Br. 31 n.14) on the alleged application of Kentucky's AWP law to the presumably relatively small number of instances in which "HMOs * * * provide only administrative services" to government and church plans. The court of appeals held that the Kentucky law does not apply to such HMOs. Pet. App. 28a n.14. In any event, the Court rejected much the same argument in *Rush*. 122 S. Ct. at 2163.

Petitioners also argue (Br. 27) that the Kentucky law is not specifically directed at the insurance industry as a matter of common sense because it "regulate[s] insurers *and providers*, by barring the latter from entering into limited network contracts with the former." That contention is mistaken. By its terms, the AWP law provides that "[a] *health insurer* shall not discriminate against any provider" who accepts the terms and conditions "established by the health insurer." Ky. Rev. Stat. Ann. § 304.17A-270 (Michie 2001) (emphasis added). Thus, the "specific obligation" of the AWP law falls only upon health insurers. *Rush*, 122 S. Ct. at 2163. As petitioners themselves elsewhere concede (Br. 3), "[t]he purpose and effect of [Kentucky's] AWP laws is to require petitioners and other HMOs to throw open their closed provider networks to any provider in the geographic area willing to abide by the terms of their network contracts." Providers need not similarly offer to enroll in the network of any health plan that wants their services.

As a result of the AWP law, health-care providers in Kentucky will be unable to find in-state insurers who will guarantee them exclusive contracts (although they may find in-state self-insured ERISA plans that will do so). But that is simply the consequence of the State's decision to regulate this particular aspect of insurers' operations. If that consequence were sufficient to remove a state law from the scope of ERISA's insurance saving clause, then *any* state law regulating *any* aspect of insurers' arrangements with providers would appear to be beyond the scope of the saving clause and, under petitioners' theory, would be preempted under Section 514(a) of ERISA. The consequences of that rule would be far-reaching. As noted above, state insurance law may regulate many aspects of the relationship between health insurers and providers whose services they cover. For example, Kentucky law requires, *inter alia*, timely payment of providers' claims; it requires insurers not to use qualification standards for providers that would screen out

high-risk populations; it requires insurers to include "hold harmless" and "continuity of care" clauses in their contracts; and it precludes provisions that would limit a provider's disclosures to a patient. See p. 2, *supra*. If petitioners' theory were correct, all of those provisions would be in danger of preemption.

2. The AWP law's location within Kentucky's Insurance Code underscores that it is an insurance regulation from a common-sense perspective. This Court has held that that classification is "relevant to the enquiry, because Congress, in leaving the 'business of insurance' to the States, 'was legislating concerning a concept which had taken on its coloration and meaning largely from state law, from state practice, and state usage.'" *Rush*, 122 S. Ct. at 2161 n.5 (quoting *SEC* v. *Variable Annuity*, 359 U.S. 65, 69 (1959)). Accordingly, a State's determination that a particular measure is the regulation of insurance is entitled to respect under ERISA. In this case, Kentucky's AWP law is found in a chapter of its Insurance Code and alongside provisions requiring coverage of, *inter alia*, mammograms, maternity, and diabetes—*i.e.*, alongside the kind of mandated-benefit provisions the Court held to fall within the insurance saving clause in *Metropolitan Life*. See Ky. Rev. Stat. Ann. §§ 304.17A-133, 304.17A-145, 304.17A-148 (Michie 2001). Indeed, the AWP law was enacted as part of a wide-ranging health insurance reform that also included many other laws governing managed care plans. 1998 Ky. Acts 496 §§ 13 (AWP law), 26 (requiring disclosure of terms and conditions of health plan), 27 (requiring, *inter alia*, printed copy of provider directory), 28 (requiring sufficient number of primary care providers and specialists in network), 30 (creating standards for provider participation); see also p. 2, *supra*, (identifying other state laws in same chapter governing provider contracts).

3. The ERISA insurance saving clause protects more than state regulation of the contract between insurer and

insured. See, *e.g.*, *John Hancock*, 510 U.S. at 98 (finding state law concerning management of an insurer's general account assets saved under insurance saving clause); *FMC Corp.*, 498 U.S. at 63 (recognizing the "distinction between *insurers of plans* and the contracts of those insurers, which are subject to direct state regulation" by virtue of insurance saving clause, and self-insurers, "which are not") (emphasis added). Nonetheless, the AWP law's important effect on the contractual arrangement between insurer and insured supports the conclusion that it "regulates insurance."

The AWP law's effect on the basic insurance contract is most clearly illustrated by the provision of Kentucky law that requires insurers to inform enrollees of the operation of the AWP law; the insurer must disclose "in writing *to a covered person and an insured or enrollee* * * * that if the provider meets the insurer's enrollment criteria and is willing to meet the terms and conditions for participation, the provider has the right to become a provider for the insurer." Ky. Rev. Stat. Ann. § 304.17A-505(1)(k) (Michie 2001) (emphasis added). The purpose of the notice obviously is not merely to inform the insured of some irrelevant business practice engaged in by the insurer. Instead, the notice is based on a recognition that the AWP law bears directly on the scope of the insurance policy: if the insured can convince a provider to become a member of the insurer's network, the insurer must provide coverage under the insurance policy for services furnished by that provider. Moreover, the notice provision reflects the reality that many insureds' primary concern in choosing an insurer is whether the family doctor is a covered provider. Petitioners accordingly are mistaken in asserting (Pet. 29) that "AWP laws concededly do *not* alter, regulate or affect the terms of insurance policies." The Kentucky AWP law was intended to—and does—directly affect the terms of the relationship between insurer and insured.

More generally, petitioners err in contending that the AWP law "simply do[es] not relate to *any* question of what risks of loss are covered or how widely they are spread" (Br. 25) and that the AWP law "regulate[s] an HMO practice * * * that is *not* an 'insurance practice'" (Br. 30-31). The AWP law in fact has a crucial bearing on the scope of the insurance offered and the coverage of risks. Without the AWP law, an HMO would be free to offer a health insurance policy that in effect contained a term under which the costs of medical services are covered only if the insured obtained those services from specific providers. Under the AWP law, however, a health insurance policy must in effect contain a term under which the costs of medical services are covered as long as the insured obtains the services from any provider who complies with the insurer's fee structure and qualification requirements. The first policy contains a restriction on the payment or furnishing of medical service for a covered risk that the second does not.

There is a difference of opinion about which type of policy is better from a social-policy perspective.[2] And in some cases, there may be little difference in practice between the two types of coverage—where, for example, the insured's provider of choice would have been selected by the HMO in any event, or does not want to provide service on the HMO's

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[2] While AWP laws are enacted to promote freedom of provider choice for patients and may make it easier for patients to shift from one plan to another, critics of such laws contend that they unduly interfere with the ability of HMOs and other insurers to negotiate discounted fees from providers, who can be promised a higher volume of patients if the network is kept limited. See Pet. App. 34a n.18 (citing James W. Childs, Jr., *You May Be Willing, But Are You Able?: A Critical Analysis of "Any Willing Provider" Legislation*, 27 Cumb. L. Rev. 199, 210 (1996-1997)); see also Briefs of Amici American Association of Health Plans, Inc., and Society for Human Resource Management. Those policy issues have no bearing on the question whether the Kentucky AWP law is preempted by ERISA. See *Pegram* at 530 U.S. 221 ("[S]uch complicated factfinding and such a debatable social judgment are not wisely required of courts.").

terms. But there can be no question that the two types of coverage may be quite different—where, for example, an insured has moved from one plan to another and wants to continue to use the services of a particular provider who is willing but unable to join the new plan. The two types of coverage are therefore surely distinct, just as each is in turn distinct from standard indemnity insurance, which traditionally insures risks regardless of which provider the insured chooses to use. The AWP law thus addresses an important aspect of the scope of coverage and a condition on payment by a health insurer.

Finally, petitioners' contention (Br. 26) that an HMO's contracts with providers are exclusively concerned with the HMO's furnishing of health care, and do not concern the HMO's furnishing of insurance, is incorrect. Given the complex relations between those two aspects of an HMO, it may be impossible to draw a clear distinction between them for present purposes. See *Rush*, 122 S. Ct. at 2161 (noting that a "dominant feature [of HMOs] is the combination of insurer and provider," and that "[a] common characteristic" of HMO-like entities in recent years is "the degree to which the roles of insurer and provider became integrated"); cf. *Pegram*, 530 U.S. at 228-229 (many, if not most, HMO eligibility and treatment decisions cannot be untangled). But "[n]othing in the saving clause requires an either-or choice between health care and insurance in deciding a preemption question, and as long as providing insurance fairly accounts for the application of state law, the saving clause may apply." *Rush*, 122 S. Ct. at 2160. Providing insurance "fairly accounts" for the application of Kentucky's AWP law in this case.

Indeed, the identical issue in this case could arise in the context of indemnity insurance, in which the insurer has no obligation to provide health care at all. In the absence of the AWP law, an indemnity insurer could offer to indemnify an insured against medical costs for services provided by a single provider or a set list of providers. Such a policy would

provide a different scope of coverage than a policy that offers (as the AWP law requires) to indemnify an insured against medical costs for services provided by any provider who satisfies certain cost and qualification standards. It would also provide a different scope of coverage than a policy offering to indemnify an insured against medical costs for services provided by any provider at all. A State's decision to require one of those distinct forms of coverage in the context of pure indemnity insurance would unambiguously involve the regulation of insurance. It follows that a State's decision to regulate an HMO's decision to offer one or the other of those types of policies is equally a law that "regulates insurance" within the meaning of ERISA's insurance saving clause. It would, moreover, be contrary to this Court's repeated recognition that the regulation of health care is left to the States under ERISA to conclude that the AWP law, as applied to HMOs, is not saved from preemption as a law that "regulates insurance" offered by HMOs because the AWP law also affects the furnishing of health care by HMOs.

B. Consideration Of The McCarran-Ferguson Factors, As Applicable In The ERISA Context, Confirms That Kentucky's AWP Law Is Covered By ERISA's Insurance Saving Clause

After analyzing a state law as a matter of common sense, the Court "then test[s] the results of the common-sense enquiry by employing the three factors used to point to insurance laws spared from federal preemption under the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*" *Rush*, 122 S. Ct. at 2159. In the ERISA context, those three factors—(1) whether the law transfers or spreads the policyholder's risk, (2) whether the law affects an integral part of the policy relationship, and (3) whether the law is limited to entities within the insurance industry—are helpful "guideposts, not separate essential elements . . . that must each be satisfied

to save the State's law." *UNUM*, 526 U.S. at 374 (internal quotation marks omitted); see *Rush*, 122 S. Ct. at 2163. In this case, those guideposts confirm the conclusion that the Kentucky AWP law "regulates insurance."

1. The court of appeals ruled that the AWP law satisfies the first, risk-spreading factor under ERISA because it has the effect of spreading the insureds' risk by providing them with more physicians to choose from and thereby reducing the likelihood that they will receive medical care outside the network and personally shoulder the cost of treatment. Pet. App. 31a; accord *Stuart Circle Hosp. Corp.* v. *Aetna Health Mgmt.*, 995 F.2d 500, 503 (4th Cir.), cert. denied, 510 U.S. 1003 (1993); see *Express Scripts, Inc.* v. *Wenzel*, 262 F.3d 829, 838 (8th Cir. 2001); *Texas Pharmacy Ass'n* v. *Prudential Ins. Co. of Am.*, 105 F.3d 1035, 1041 (5th Cir.), cert. denied, 522 U.S. 820 (1997); *Blue Cross & Blue Shield* v. *Bell*, 798 F.2d 1331, 1334-1335 (10th Cir. 1986).

More fundamentally, in the context of the preemption of a state law under the McCarran-Ferguson Act, a law affecting the *performance* of an insurance contract satisfies the risk-spreading factor, because "[w]ithout performance of the insurance policy, there is no risk transfer at all." *Fabe*, 508 U.S. at 503-504. Here, the Kentucky AWP law addresses the performance of insurance policies by removing a condition on the payment of the costs of treatment for a covered risk—namely, the condition that the treatment will be covered only if it is furnished by a provider who has been selected by the insurer to be a member of its closed network.[3]

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[3] Looked at in another way, for many HMOs, performance of the insurance contract is accomplished by furnishing medical services in kind through providers in the HMO's network, rather than by monetary payments to indemnify the insured for costs incurred in receiving services from any provider chosen by the insured. The Kentucky AWP law regulates the performance of the insurance contract by such HMOs by specifying which providers' services may be furnished in kind in fulfillment of the HMO's insurance obligation.

2. As the court of appeals correctly concluded, Pet. App. 35a-36a, the AWP law also "serves as 'an integral part of the policy relationship between the insurer and the insured.'" *UNUM*, 526 U.S. at 374 (quoting *Metropolitan Life*, 471 U.S. at 743); see also Pet. App. 36a; *Stuart Circle*, 995 F.2d at 503. Like other mandated-benefit provisions, the AWP law's mandate of open networks fundamentally changes the underlying insurance promise between the insurer and insured. See *Metropolitan Life*, 471 U.S. at 744 (state regulation affecting "*the type of policy which could be issued*" is part of "the core of the 'business of insurance'") (emphasis added); see also *UNUM*, 526 U.S. at 374 (notice-prejudice rule integral to relationship by changing bargain between insurer and insured); *Texas Pharmacy Ass'n*, 105 F.3d at 1041. The AWP law, although not mandating coverage of a specific condition (as in *Metropolitan Life*), nevertheless defines the scope of the benefits provided and mandates the type of policy that may be issued. See *Fabe*, 508 U.S. at 501 (McCarran-Ferguson Act applies to statutes that "directly or indirectly" regulate insured-insurer relationship) (quoting *SEC* v. *National Secs., Inc.*, 393 U.S. 453, 460 (1969)). Moreover, for many insureds, knowing whose services are covered is as important a part of the insurer-insured relationship as knowing which services are covered. Indeed, petitioners' own contention that AWP laws make it difficult for HMOs to limit the number of providers in their networks necessarily implies that AWP laws make it likely that insureds will enjoy greater choice in selecting providers.

The significance of the provider network to HMO health insurance cannot be overstated. HMOs determine who provides health care to their members. A member may not obtain health care from providers outside the network and expect the HMO to pay for it, unless the policy specifically

contains that benefit.[4] Thus, the provider network—the totality of provider contracts—fundamentally defines the HMO's insurance obligation to the insured, and AWP laws, by affecting provider networks, in turn affect the insurance provided by HMOs. See *UNUM*, 526 U.S. at 374-375; see also Pet. App. 23a; *Express Scripts*, 262 F.3d at 837-838; *Texas Pharmacy Ass'n*, 105 F.3d at 1041.

3. For essentially the same reasons that the AWP law regulates insurance as a matter of common sense, see pp. 11-18, *supra*, the court of appeals correctly held that the law satisfies the third McCarran-Ferguson factor. The AWP law is "aimed at" the insurance industry, *UNUM*, 526 U.S. at 375 (quoting *FMC Corp.*, 498 U.S. at 61)—*i.e.*, at insurers and entities acting as insurers. Accord *Rush*, 122 S. Ct. at 2164 (third factor requires the targets of the law to be "limited to entities within the insurance industry"). Under any construction, the AWP law has no application outside the context of insurance; it is not a law of broad or general application that happens to include health insurers within its reach. Compare *UNUM*, 526 U.S. at 368-373, with *Pilot Life*, 481 U.S. at 50-51.

4. For the reasons given above, the common-sense test, as well as the three McCarran-Ferguson Act "guideposts," are satisfied in this case. *UNUM*, 526 U.S. at 374. At the very least, the aggregation of the considerations relevant under the three interrelated factors drawn from McCarran-Ferguson Act cases confirms what is evident as a matter of common sense—that a state law that regulates which providers' services will be eligible for coverage under an insurance policy is saved as a law that "regulates insurance."

III. *ROYAL DRUG* DOES NOT CONTROL THIS CASE

Petitioners base essentially all of their argument on the proposition that this Court has already resolved the question

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[4] Kentucky requires HMOs to offer out-of-network benefits under certain conditions. Ky. Rev. Stat. Ann. § 304.17A-550 (Michie 2001).

presented in this case in *Royal Drug*. See Pet. Br. 14-26. Petitioners' argument, however, both ignores the critical distinctions between this case and *Royal Drug*, and rests on a misunderstanding of the appropriate analysis under ERISA's insurance saving clause.

A. The Subject Of The Legal Inquiry In *Royal Drug* Was Distinct From The Subject Of The Inquiry Here

Royal Drug involved an arrangement between an indemnity insurer and pharmacies, under which the insurer agreed to reimburse pharmacies for their costs of drugs to be provided to insureds, so long as the pharmacies charged the insureds only two dollars per prescription. Although the insurer offered that arrangement to all pharmacies, not all pharmacies chose to participate on those terms. 440 U.S. at 209. This Court held that the agreements were not exempt from the federal antitrust laws under Section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. 1012(b), based on several considerations that were later crystallized in *Pireno* "as three characteristics of the business of insurance that Congress intended to exempt" from the antitrust laws. *Union Labor Life Insur. Co.* v. *Pireno*, 458 U.S. 119, 127 (1982). *Royal Drug* differed substantially from this case in at least two respects of significance to the ERISA insurance saving clause analysis.

First, in contrast to the private agreements at issue in *Royal Drug*, state AWP laws do not merely set the rate at which an insurer will reimburse a provider who is already a member of the insurer's provider network—a matter with which policyholders are "basically unconcerned." 440 U.S. at 214; see also *Pireno*, 458 U.S. at 132 (policyholder's "only concern is whether his claim is paid"). AWP laws regulate who may be included in the network at all, *i.e.*, which doctors and other providers are available to an insured. Pet. App. 32a. That is a matter in which policyholders are likely to have a keen interest. The Kentucky AWP law regards in-

sureds as directly affected by—and greatly interested in—its mandates and for that reason requires that insureds be directly notified of them by the insurer. Cf. *Rush*, 122 S. Ct. at 2163-2164 (distinguishing state law giving a right to independent medical review to obtain a binding determination on a claim, from an insurer's voluntary use of a peer review committee to assist it in making initial claims determinations, which was "no concern of the insured").

Second, the subject of the legal inquiry in *Royal Drug* was a voluntary practice adopted by the insurer in its contractual arrangements with pharmacies, and the question was whether those *private agreements* between the insurer and providers outside the insurance industry were exempt from the federal antitrust laws as part of the private "business of insurance." See 440 U.S. at 207. The Court concluded that they were not, reasoning, *inter alia*, that an entity that is exempt from the antitrust laws ordinarily forfeits its immunity "by acting in concert with nonexempt parties." *Id.* at 231; accord *Pireno*, 458 U.S. at 133; *Fabe*, 508 U.S. at 503.

By contrast, the subject of the legal inquiry in this case under ERISA's insurance saving clause is a *state law*, not private agreements. And as explained above, (see p. 13, *supra*), the state AWP law imposes an obligation only on insurers. The state law does not impose any obligation on providers. Nor does it purport to exempt any private agreements between insurers and providers from the federal antitrust laws. In sum, there is a substantial difference between the question whether a private agreement between an insurer and providers is exempted from the antitrust laws and the question whether a state law directed at insurance is preempted by ERISA.

B. The McCarran-Ferguson Act Analysis In *Royal Drug* May Inform, But Does Not Control, The ERISA Insurance Saving Clause Analysis

1. From its first decision construing the ERISA insurance saving clause in *Metropolitan Life*, this Court has never suggested that the McCarran-Ferguson Act analysis, as applied in *Royal Drug* or other cases, controls the application of the ERISA clause. In *Metropolitan Life* itself, the Court began with a "common-sense view" of what constitutes a law that "regulates insurance" under the ERISA clause. 471 U.S. at 740-742. Only after concluding that the state mandated-benefits law in *Metropolitan Life* constituted a regulation of insurance within the ordinary meanings of those terms did the Court go on to consider the McCarran-Ferguson factors. Even then, the Court did not hold that the analysis applied in the *Royal Drug* context is necessary to determine the applicability of the ERISA clause.

Petitioners' theory that the McCarran-Ferguson factors as applied in *Royal Drug* are dispositive in the ERISA context is inconsistent with *Metropolitan Life*. Had the Court agreed with petitioners' theory, the Court would have had no need to construct and apply a "common-sense" inquiry for use in ERISA insurance saving clause cases, either in *Metropolitan Life* or in succeeding cases. See, *e.g.*, *Rush*, 122 S. Ct. at 2163-2164; *UNUM*, 525 U.S. at 373-375; *Pilot Life*, 481 U.S. at 50-51. Indeed, while the Court has treated the McCarran-Ferguson factors as guideposts that confirm the conclusion reached by the common-sense test, it has never found a state law to regulate insurance under ERISA as a matter of common sense, but then not as a matter of law, based on an application of factors drawn from that *different* (and differently worded) statute.

2. This Court's use of the McCarran-Ferguson factors in ERISA cases confirms their complementary role in informing the common-sense test. The Court has referred to the

McCarran-Ferguson factors as "guides" or "considerations [to be] weighed," *Pilot Life*, 481 U.S. at 48, or as "guideposts," *Rush*, 122 S. Ct. at 2163, and has stated that they are "criteria relevant to" the ERISA inquiry, *Metropolitan Life*, 471 U.S. at 743. See *UNUM*, 526 U.S. at 373 ("[W]e called the * * * factors 'relevant'; we did not describe them as 'required.'"). Indeed, in two cases, the Court has found state laws to be regulations of insurance under the ERISA saving clause without mentioning the McCarran-Ferguson factors: *FMC Corp.*, in which the Court found a state anti-subrogation provision to be a law that regulates insurance, see 498 U.S. at 61, and *John Hancock*, in which the Court found a state law concerning management of an insurer's general account assets to be a law that regulates insurance, see 510 U.S. at 99. Thus, both the manner in which this Court has considered the McCarran-Ferguson factors in the ERISA context, and the Court's failure to consider them in other ERISA insurance saving clause cases, belie petitioners' argument that the McCarran-Ferguson factors control the application of the ERISA insurance saving clause.

3. There is good reason for the McCarran-Ferguson factors—especially as applied in *Royal Drug*—to play a distinctly secondary role in the ERISA context. Although the ERISA insurance saving clause has wording that is "similar[]" to that of the McCarran-Ferguson Act, *Metropolitan Life*, 471 U.S. at 744 n.21, it is not identical. The ERISA clause saves any state law "which regulates * * * insurance." 29 U.S.C. 1144(b)(2)(A). Section 2(b) of the McCarran-Ferguson Act has two relevant clauses, one of which saves any state law "enacted * * * for the purpose of regulating the business of insurance," and the other of which adds the proviso that the federal antitrust laws "shall be applicable to the business of insurance to the extent that such business is not regulated by State law." 15 U.S.C. 1012(b). Thus, while the ERISA clause broadly saves laws that regulate "insurance," the McCarran-Ferguson Act

applies in accordance with the more limited term "business of insurance." This Court has carefully parsed the term "business of insurance," *Hartford Fire Ins. Co.* v. *California*, 509 U.S. 764, 781 (1993), distinguishing it from the "business of insurance companies," *ibid.*; *SEC* v. *National Secs. Inc.*, 393 U.S. at 459-460, and holding that not everything an insurance company does is within the "business of insurance." *Royal Drug*, 440 U.S. at 211. By its terms, the ERISA saving clause saves the regulation of "insurance" more generally. The difference in language alone indicates that the ERISA saving clause and the McCarran-Ferguson Act have different scopes. Moreover, nothing in the legislative history of ERISA suggests that Congress intended the ERISA and McCarran-Ferguson language to be construed identically.

4. The special context in which the McCarran-Ferguson factors were applied in *Royal Drug* further demonstrates that that application cannot simply be imported categorically into the ERISA context. Rather, factors that originated in the context of an exemption from the antitrust laws under the McCarran-Ferguson Act can be considered under the insurance saving clause only "'*mutatis mutandis*,' *i.e.*, '[a]ll necessary changes having been made," *Shalala* v. *Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 17 (2000) (quoting *Black's Law Dictionary* 1039 (7th ed. 1999)), to take account of the quite different statutory framework and policies of ERISA.

As the Court in both *Fabe* and *Royal Drug* itself explained, *Royal Drug* involved the *second* clause of Section 2(b), which accomplishes Congress' "secondary goal" in enacting the McCarran-Ferguson Act, which was to carve out only a *narrow* exemption for 'the business of insurance' from the federal antitrust laws." *Fabe*, 508 U.S. at 505 (emphasis added); see *Royal Drug*, 440 U.S. at 218 n.18. In *Royal Drug* itself, this Court emphasized that it was therefore applying the "well settled" principle that "exemptions from the antitrust laws are to be narrowly construed." *Id.* at 205. Accord

Pireno, 458 U.S. at 126; *Abbott Labs.* v. *Portland Retail Druggists Ass'n*, 425 U.S. 1, 11-12 (1976); *FMC* v. *Seatrain Lines, Inc.*, 411 U.S. 726, 733 (1973); *United States* v. *McKesson & Robbins, Inc.*, 351 U.S. 305, 316 (1956). By contrast, the *first* clause of Section 2(b) of the McCarran-Ferguson Act, which saves state laws "enacted for the purpose of regulating the business of insurance," "was intended to further Congress's primary objective of granting the States *broad* regulatory authority over the business of insurance." *Fabe*, 508 U.S. at 505 (emphasis added); cf. 15 U.S.C. 1011 (declaration of policy of McCarran-Ferguson Act that "continued regulation and taxation by the States of the business of insurance is in the public interest"). Accordingly, this Court in *Fabe* construed the first clause of Section 2(b) expansively and made clear that the relevant analysis is more flexible than in *Royal Drug* and *Pireno*, in order to achieve Congress's purpose of broadly saving state law in an area of traditional state regulation. 508 U.S. at 500-501, 504-505.

In short, the analysis in *Royal Drug* was expressly influenced by a narrow construction rule and the policy considerations underlying it—a rule and policy that the Court in *Royal Drug* and *Fabe* made clear has no application in the context of the first clause of Section 2(b) at issue in *Fabe*. In *Fabe*, the policy against displacement of traditional state regulatory authority, rather than the policy favoring a narrow construction of antitrust exemptions, was in play. Indeed, in *Royal Drug* itself, the Court strongly suggested that, although the agreements between insurers and pharmacies in that case fell outside the narrow exemption from the federal antitrust laws in the second clause of Section 2(b) of the McCarran-Ferguson Act, those agreements could be regulated by state law in accordance with the first clause of Section 2(b). See 440 U.S. at 218 n.18.

The ERISA insurance saving clause implicates the policies underlying *Fabe* (the preservation of state law) rather than those implicated in *Royal Drug* (the narrow construc-

ton of antitrust exemptions). The ERISA insurance saving clause was designed "broadly to preserve the States' law-making power," *Metropolitan Life*, 471 U.S. at 740, and thereby "reclaim a substantial amount of ground" for state regulation, *Rush*, 122 S. Ct. at 2158. Indeed, this Court in recent years has repeatedly emphasized that under ERISA there is a "starting presumption that Congress does not intend to supplant state law," which is of particular strength "in fields of traditional state regulation" such as insurance and health care. *Travelers*, 514 U.S. at 654, 655; *De Buono*, 520 U.S. at 813 & n.8; *Dillingham* 519 U.S. at 325. ERISA's saving clause thus serves the same basic policies as the law in *Fabe*, and markedly different policies than those involved in *Royal Drug*. In fact, the conclusion that *Royal Drug* does not control the analysis under ERISA follows *a fortiori* from *Fabe*, because, as noted, ERISA saves a broader class of state laws (all those that "regulate[] insurance") than does the first clause of Section 2(b) of the McCarran-Ferguson Act (which saves state laws enacted for the "purpose of regulating the *business* of insurance," 15 U.S.C. 1012(b) (emphasis added).

C. Petitioners' Own Arguments, If Accepted, Would Establish That The AWP Law Is Not Preempted Because It Does Not "Relate To" ERISA Plans To Begin With

Petitioners' reliance on *Royal Drug* in arguing that the Kentucky AWP law is preempted fails for another reason as well. Petitioners take the position (Br. 12), with which we agree, that the AWP law relates to ERISA plans under Section 514(a) because it "affect[s] both plan administration and plan benefits." But petitioners then argue (Br. 20) that AWP laws solely regulate the business practices of HMOs and their relationships with providers, who are one step further removed from ERISA plans than insurers, and that AWP laws therefore do "not alter, regulate or affect the terms of insurance policies." See also Pet. Br. 25 ("[T]he

particular nature of the arrangements with providers the HMO makes—whether they are on a limited basis or not—are immaterial to" the HMO's "obligation to provide care."). In petitioners' view, AWP laws simply prohibit arrangements used by HMOs to minimize their own costs. The structure of a provider's network—whether open or closed—has only a "speculative, marginal" effect on the individuals it insures (Pet. Br. 34) and is not a matter of legitimate concern to them.

If petitioners' later contentions were correct, then petitioners' initial premise—that AWP laws "relate to" ERISA plans in the first place—would be incorrect. Under petitioners' reasoning, AWP laws would have no more effect on ERISA plans than many other contracting practices involving third parties that an HMO might engage in to control its costs. This Court has held that such mere "indirect economic effect[s]" on an ERISA plan are insufficient to warrant a finding that the law imposing those effects "relates to" the plan within the meaning of Section 514(a). See *Travelers*, 514 U.S. at 662. That is especially true where "relates to" preemption would "displace general health care regulation which historically has been a matter of local concern." *Id.* at 661. See *id.* at 663; *De Buono*, 520 U.S. at 815-816. Cf. *Metropolitan Life*, 471 U.S. at 741 ("[L]aws that regulate only the insurer, or the way in which it may sell insurance," and do not regulate the "substantive terms of insurance contracts," "do not 'relate to' benefit plans in the first instance.").

In short, petitioners' core argument under the insurance saving clause is that AWP laws have little or nothing to do with the provision of insurance to ERISA plans. If so, the same argument would establish that AWP laws have little or nothing to do with ERISA plans and are therefore not subject to "relates to" preemption under Section 514(a). Petitioners cannot have it both ways, arguing that the Kentucky AWP law is both so closely connected to an ERISA plan

because of its impact on plan benefits that it "relates to" ERISA plans for purposes of ERISA's principal preemption provision, *and* that its operation is so distant from the relationship between an insurer and ERISA plans and their insured members that it does not even constitute a law that "regulates insurance."

The tension between the "relate[s] to" clause and the insurance saving clause created by petitioner's argument is best resolved by recognizing that *Royal Drug* was quite distinguishable from this case with respect to both the subject of the case and the federal statutory provision under which it arose (a narrow exemption from the federal antitrust laws rather than a broad preservation of state laws regulating insurance). Kentucky's AWP law affects both the type of insurance policy that may be issued to ERISA plans and the benefits received by plan members who are insured under the policy. It therefore relates to ERISA plans, but is saved from preemption as a law regulating insurance.

CONCLUSION

The judgment of the Sixth Circuit should be affirmed.

Respectfully submitted.

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* The Solicitor General is recused in this case.

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IN THE

Supreme Court of the United States

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., *et al.*,

Petitioners,

v.

JANIE MILLER, COMMISSIONER OF THE KENTUCKY DEPARTMENT OF INSURANCE,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF OF *AMICI CURIAE* AMERICAN ASSOCIATION OF HEALTH PLANS, INC., HEALTH INSURANCE ASSOCIATION OF AMERICA, NATIONAL ASSOCIATION OF MANUFACTURERS AND BLUE CROSS BLUE SHIELD ASSOCIATION IN SUPPORT OF PETITIONERS

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STATEMENT OF INTEREST[1]

The American Association of Health Plans, Inc. ("AAHP") is the national association for the managed care community. Its membership includes health maintenance organizations, preferred provider organizations, third-party health plan administrators, health care utilization review organizations, prepaid limited health service plans, and other integrated health care delivery systems. AAHP represents more than 1,000 managed health care organizations serving nearly 160 million Americans, the majority of whom are participants or beneficiaries of employee benefit plans under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq*. AAHP's mission is to advance health care quality and affordability through leadership in the health care community, advocacy and the provision of services to member health plans.

The Health Insurance Association of America ("HIAA") is the nation's most prominent trade association representing the private health care system. Its nearly 300 members provide health, long-term care, dental, disability, and supplemental coverage to more than 100 million Americans. HIAA develops and advocates federal and state policies that build upon the health care system's quality, affordability, accessibility and responsiveness. It is the nation's premier provider of self-study courses on health insurance and managed care.

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1. The parties have consented to the filing of this brief. Their letters of consent are on file with the Clerk of the Court. This brief has been authored in its entirety by undersigned counsel for the *amici curiae*. No person or entity, other than the named *amici curiae* and their counsel, made any monetary contribution to the preparation and submission of this brief.

The National Association of Manufacturers ("NAM") — 18 million people who make things in America — is the nation's largest industrial trade association. The NAM represents 14,000 members (including 10,000 small and mid-sized companies) and 350 member associations serving manufacturers and employees in every industrial sector and all 50 states.

The Blue Cross Blue Shield Association ("BCBSA") comprises 42 independent, locally operated Blue Cross and Blue Shield Plans. The Blue Cross and Blue Shield companies provide, through relationships with employers, employee benefits plans, and direct contracts with subscribers, health insurance to private and public employees and individuals, including fee-for-service programs, health maintenance organizations, preferred provider organizations, and a variety of other offerings. They also provide third-party administrative services to private and public employee benefits plans. Collectively, the Blue Cross and Blue Shield companies furnish health care coverage to 84.5 million — or one in four — Americans, making them (as a group) the largest U.S. entity offering health insurance and benefits.

As members of the health plan, health insurance and business communities, Amici AAHP, HIAA, NAM and BCBSA have vital interests in the federal questions presented by this case under the ERISA statute. The member organizations of amici AAHP, HIAA, NAM and BCBSA fund, provide, arrange for, insure or administer, on behalf of employers with self-funded ERISA health benefit plans, the provision of covered health services to participants and beneficiaries ("Ps&Bs") of employee benefit plans regulated

by the Employee Retirement Income Security act of 1974 ("ERISA"). 29 U.S.C. § 1001, *et seq.* (as amended). The members of amicus NAM, are employers, and "employment is the source of health care coverage for two-thirds (67%) of this country's population." Paul Fronstin, *Number of Americans with Job-Based Health Benefits Increased in 2000 While Uninsured Declined*, EMPLOYEE BENEFIT RESEARCH INSTITUTE NEWSLETTER, Vol. 22, No. 11 (Nov. 2001) pp. 1-2.

Amici have joined together to file this brief in support of Petitioners' Brief on the Merits because the Sixth Circuit Court of Appeals' decision in *Kentucky Association of Health Plans, Inc. v. Nichols*, 227 F.3d 352 (6th Cir. 2000) is unsupported by ERISA and by decisions of this Court that are directly on point, and because of the extraordinarily destabilizing effects of the holding upon both: (a) providers of health care benefit coverages and benefit administration services; and (b) the purchasers and payors of such services.

The Sixth Circuit's decision which holds that Kentucky's "Any Willing Provider" statutes ("AWP") are saved from preemption under ERISA will have a significantly adverse effect on the ability of both managed care organizations ("MCOs"), such as the members of AAHP, HIAA and BCBSA, and employers, such as the members of NAM, to control the increasing rate of inflation in the cost of health care and health care coverage. As the lower court recognized, its decision allows states to interfere with ERISA benefit plan design and administration. *Id.* at 358-63, 372-73. Critically, the decision rests on the wholly mistaken premise that AWP laws benefit Ps&Bs of either insured or self-funded ERISA plans. To the contrary, the only persons and entities whose interests are advanced and protected by AWP statutes are health care providers, not their patients.

SUMMARY OF THE ARGUMENT IN SUPPORT OF PETITIONERS' BRIEF ON THE MERITS

The holding of the Sixth Circuit Court of Appeals threatens the financial ability of the Nation's employers to provide comprehensive health benefits to their employees who depend upon their employment for health care coverage for themselves and their dependents. That holding, if allowed to stand, eliminates long-standing and effective means of cost control utilized by HMOs and other MCOs. It effectively nullifies the determination of Congress, when it enacted the Federal Health Maintenance Organization Act of 1973, Pub. L. 93-222 (as amended), 42 U.S.C. §§ 300e, *et seq.*, that entities with controlled and limited provider networks constitute an effective and beneficial approach to the containment of health care costs.

The lower court's decision rests on two indefensible assumptions. The first is that AWP laws constitute a benefit to plan participants. That assumption might be valid if AWP laws granted to MCO members any capacity to compel providers to participate in the provider network created by their MCO, on the terms offered by the MCO. Neither Kentucky's AWP law nor those of any other state, grant any such ability to MCO members. In sum, the decision whether or not to participate in a network is left solely to the discretion of providers. KY. REV. STAT. § 304.17A-270.

AWP statutes, therefore, cannot reasonably be understood to confer an insurance benefit, indeed a benefit of any kind, to insureds, including MCO members, the risk of which is borne by MCOs. This fact alone precludes any possibility that the insurance Savings Clause[2] (the "Savings Clause")

2. 29 U.S.C. § 1144(b)(2)(A).

exception to ERISA's preemption provisions can apply to Kentucky's AWP law. The only risk to which Kentucky's AWP statute exposes MCOs is the risk that a provider may choose to participate in their network when the financial calculus works in the provider's favor. Providers, however, are not insureds. The risk that a provider may find it economically advantageous to force its entry into a network cannot be characterized as an insurance risk under any reasonable meaning of that term.

The second untenable assumption is that the provision of Kentucky's AWP statute which states that any provider who elects to join the network must accept the terms of participation offered by the network actually can operate to prevent the MCOs' costs of providing care from increasing. KY. REV. STAT. § 304.17A-270. As a simple matter of economic common sense and reality, however, it is plain that the inability of MCOs to control the number of providers in their network deprives them of the ability to negotiate rates on the basis of volume discounts. Under an AWP statute regime, an MCO cannot tender an assurance of any kind to providers that their direct competitors will be excluded from the MCO's network and from having access to the MCO's members. Consequently, providers have little, or no, incentive to agree to charge the MCO materially discounted rates for their services to the MCO's members.

There are other forms of adverse economic effects caused by AWP statutes that the Sixth Circuit's decision permits, none of which confer additional benefits to MCO members or transfer risk to MCOs. The addition of providers to a network is not a cost free exercise for the MCO. For example, there are the provider applications to be processed. This includes provider credentialing, the costs of educating the provider, or

its billing staff, on how to submit claims in compliance with the MCO's criteria, and supervising the compliance of additional providers with the MCO's quality and utilization criteria. All of these costs are passed to MCO members and employers, and not a penny's worth of those costs is spent on the provision of additional health care to MCO members.

Remarkably, the lower court ignores the complete absence of any evidence in the record that the AWP law addresses or rectifies any alleged or documented coverage or health care quality gaps that adversely affect Kentucky's MCO members. Nothing in the record documents that either the quality or the quantity of the care received by MCO members was deficient, much less deficient in any manner that is addressed or ameliorated by the provisions of the AWP statute.

Indeed, AWP laws may have the effect of diminishing the average quality and competence of the providers in an MCO's network, particularly with respect to certain specialties. As amici hereafter demonstrate, AWP statutes impair the capacity of MCOs to: (a) control the quality of the providers they allow in their networks; and (b) periodically evaluate the quality and efficiency of the care network providers deliver to their patients who are MCO members. In addition to the public health implications of these impairments, the forcible inclusion of providers in an MCO's network has adverse liability implications for MCOs which, under a number of legal theories, have been held accountable for the negligent acts of the providers in their networks. AWP statutes such as Kentucky's law here at issue create quality control and liability burdens and exposures for MCOs, without improving the quality of care available to or received by their members. They also fail to provide MCOs with any means with which to manage those additional burdens other

than, of course, incurring additional costs that will increase the current double digit rate of inflation for health care coverage.[3]

ARGUMENT

A. AWP Statutes Confer No Benefits Upon MCO Members.

1. Only Providers Have Rights Under AWP Statutes.

There is no advantage to the Court for the amici to present what would be a redundant demonstration of the clear errors of law in the Sixth Circuit's ERISA Insurance Savings Clause (the "Savings Clause"), 29 U.S.C. § 1144(b)(2)(A), analysis. The Petitioners Opening Brief addresses that issue comprehensively. Amici will focus upon a critical misunderstanding by the lower court of the purpose and effects of AWP laws.

Amici submit that the Sixth Circuit Court of Appeals, as well as the Fourth Circuit Court of Appeals in its decision in *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993), erred because they failed to acknowledge a fundamental characteristic of AWP statutes. AWP statutes provide no rights, benefits, entitlements or

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3. According to the Kaiser Family Foundation annual national survey of employer health benefit plans, "Between Spring of 2001 and Spring of 2002, monthly premiums for employer-sponsored health insurance rose 12.7%. . . ." Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits 2002 Summary of Findings" 2002, www.kff.org. *See also*, *Health Insurance Prognosis is Poor*, THE WASHINGTON POST, September 6, 2002, Section E at pp. 1 and 4.

privileges to MCO members. This is so even if such members' coverage is through insurance rather than through a self-funded ERISA plan administered by an MCO. Under an AWP statute, an MCO member has no individual capacity to either: (a) compel an MCO plan to include a provider in its network or; (b) to compel a provider to participate in such a network. If that provider does not choose to seek admission to the network, the MCO member is utterly powerless under AWP statutes to do anything about that circumstance.

There is no provision under the AWP statutes of either Kentucky or Virginia (Virginia Code 38.2-3407) which enable MCO members to compel a provider to agree to the compensation terms of an MCO. If, as a hypothetical matter, AWP statutes empowered MCO members to compel providers to participate in an MCO's network upon terms generally offered to similarly situated providers by the MCO, there arguably would exist some benefit that was conferred upon the MCO member. That circumstance would justify an argument whether the benefit involved a transfer of risk that qualified as the "business of insurance" under the Savings Clause. Amici submit that, in any event, even this "benefit" would not qualify as a transfer of risk within the meaning of the term "business of insurance." The ability of an MCO member to compel a provider to join an MCO's network can have no impact on the actuarial or statistical probability that the member will experience a covered health event. It can only impact upon the identity of the vendor who will be paid by the MCO. This result fits squarely within the Court's ruling in *Group Life & Health Ins. Co. v Royal Drug Co.*, 440 U.S. 205, 231 (1979), that the relationship between an insurer and its vendors is not a part of the "business of insurance."

That circumstance, however, is purely a hypothetical one and does not exist. There was no objective basis for either the Sixth Circuit or the Fourth Circuit Courts of Appeal to even venture into an analysis of whether AWP laws could be saved from preemption under the Savings Clause because those laws do not confer any benefit of any kind on insureds.

2. AWP Laws Are Not Akin to State Mandated Benefit Laws.

AWP laws cannot be analogized to state laws that mandate insurers and MCOs to cover certain diseases, mental illness for example, or to include certain categories of providers in their networks, such as osteopaths. *See Metropolitan Life Ins. v. Massachusetts*, 471 U.S. 724 (1985) (Massachusetts statute requiring insurers to cover mental health benefits saved from preemption under Savings Clause.); *Blue Cross and Blue Shield of Kansas City v. Bell*, 798 F.2d 1331 (10th Cir. 1986) (State law mandating that insurers cover services by podiatrists and dentists among other specialties was not preempted). In those instances, there is a transfer of risk from insured MCO members to their MCOs, as such laws compelled the MCOs to pay for categories and types of medical services they did not previously cover, i.e., to assume new risks. *Cf. Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 127 (1982). Kentucky's AWP law is not comparable to the State law at issue in *Washington Physicians' Service Ass'n v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998). There, the statute at issue required that the services of every type of licensed health care provider be covered. *Id.* at 1042-43. It did not, as is the case with Kentucky's AWP law, empower providers to force MCOs to accept their participation in the MCO's

networks. *Id.* Under the statute at issue in *Gregoire*, an MCO might be obligated to include at least one acupuncturist in its network, but could not be compelled to admit all acupuncturists who desired to participate. *Id.*

In contrast, AWP laws such as Kentucky's do not shift or transfer any new risks, nor do they allow MCOs to limit the number of providers in their network. AWP laws do nothing more than dictate to ERISA plans which choose to have their benefits administered or provided by MCOs the identity of the providers entitled to be paid for services to plan participants. The Sixth Circuit erred in failing to recognize that state AWP laws, such as Kentucky's, that dictate to ERISA plan claim administrators who they must pay for covered benefits are preempted by ERISA. *See, e.g., Blue Cross Blue Shield of Alabama v. Nielsen*, 917 F. Supp. 1532 (N.D. Ala. 1996); *Delta Dental Plan of California v. Mendoza*, 1996 U.S. Dist. Lexis 2106 (N.D. Cal. 1996).

3. AWP Laws Offer No Quality of Care Advantages to MCO Members.

Theoretically, the argument might be advanced that AWP laws somehow improve the quality of the care available to MCO members. However, nothing in the record of this case offers any factual support for that argument. There is no evidence that the care provided to MCO members who only have access to limited provider networks compares unfavorably in any respect or degree to the care received by persons whose coverage permits them to receive care from

any provider of their choice. Indeed, a compelling argument can be made for the proposition that AWP laws adversely affect the ability of MCOs to take steps to develop networks populated by superior providers.

"[A]ny-willing-provider laws greatly hinder quality assurance." Karen A. Jordan, *Managed Competition And Limited Choice Of Providers: Countering Negative Perceptions Through A Responsibility To Select Quality Network Physicians*, 27 ARIZ. ST. L.J. 875, 918 (1995) (hereafter referred to as "*Jordan*"). This is so because a proper network should have the right mix of providers and the right providers. *Id.* at 919. For example, it has been suggested that heart surgeons should perform some 200 heart surgeries a year to "develop and maintain the skills necessary to do high-quality work." Mark A. Kadjielski, *et al.*, *Peer Review Potpourri: New Developments In Credentialing And Privileging*, 15 WHITTIER L. REV. 51, 53 (1994).[4] MCOs, therefore, in order to best serve their members, should have the ability to exercise selectivity in order to provide network physicians, specialists in particular, an adequate patient base so that their expertise and level of competence will not be diluted. *Jordan*, at 919.

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4. The American College of Cardiology also has identified and recommended minimum numbers of procedures which should be performed on an annual basis in order to maintain competency. These standards apply to both cardiologists and institutions that provide cardiology services. *See* http://www.acc.org/clinical/competence/coronary/jac5492Fla1b.htm.

It may be argued that because AWP laws require a provider to accept an MCO's network participation criteria, a provider who does not satisfy the MCO's credentialing criteria does not have to be allowed into the network. That simplistic argument overlooks, actually evades, a number of objective realities. For example, MCOs' credentialing criteria typically set qualification standards such as licensure, acceptable medical malpractice history, medical malpractice coverage at specified levels, possession of staff privileges in accessible network hospitals, board certification or board eligibility. These criteria, however, have to be flexible in application. MCOs' service areas may include medically underserved areas that have shortages of specialists, tertiary hospitals, and even primary care physicians. MCOs must be able to include in their networks for their members located in such underserved areas accessible providers whose qualifications are not on a par with those of network providers in medically better served regions of the MCOs' service area.[5] That circumstantial need, however, should not prevent MCOs from being more selective, both in terms of cost and quality, in those parts of their service area where there is a plentiful supply of providers in competition with each other. AWP laws prevent MCOs from exercising any such judgments and

5. AWP laws also create a bias towards increasing provider incomes and the cost of health care services by skewing the law of supply and demand. In a medically underserved area, the scarcity of supply, i.e., of available providers, will drive the price, or cost, of the suppliers' services upwards. Where the supply of providers is plentiful, the price of their services should move to lower levels. AWP laws interfere with that dynamic. They empower providers in a high supply market to demand inclusion in an MCO's market at the prices paid by the MCO to providers in the low supply areas on the argument that such higher prices are the "terms and conditions" of participation in their network offered by MCOs. KY. REV. STAT. § 304.17A-270.

choices. There is no sensible argument to be made for the proposition that this inability benefits MCO members in any manner.

B. The Sole Effects of AWP Laws Are To Empower Providers to Resist Price Competition and to Impair the Growth of MCOs.

The only beneficiaries of AWP laws are providers who are opposed to managed health care and seek to eliminate the ability of MCOs to negotiate discounted payments through their ability to deliver patient volumes and through the achievement of economies of scale. Jensen & Morrissey, *Employer-Sponsored Health Insurance and Mandated Benefit Laws*, THE MILBANK QUARTERLY, Vol. 77, No.4, 425, 436 (1999); Marsteller, Bovbjerg, *et al.*; *The Resurgence of Selective Contracting Restrictions*, THE JOURNAL OF HEALTH POLITICS, POLICY AND LAW, 22:1133-89 (1997). A study by the University of Alabama funded by the Robert Wood Johnson Foundation ("RWJF Study") concluded that AWP laws "are not necessarily designed to protect quality, but instead are often conceived as efforts to protect providers from the effects of competition." The Robert Wood Johnson Foundation, National Program Reports, *Research on the Effects of Any-Willing-Provider Laws*, available at http://www.rwjf.org/reports/grr/029014.htm (updated January 2001). It is not coincidence that "The proponents of any-willing-provider laws are . . . often groups of health care specialists or allied health professionals who are suddenly finding it difficult to market themselves." *Jordan*, 27 ARIZ. ST. L. J. at 919.

The Federal Trade Commission ("FTC") was requested by the Attorney General of Montana and the Senates of the

States of California and New Hampshire to provide them with its opinion on the issue whether AWP laws impair competition.[6] In every instance, the FTC concluded that impairment of competition was the inevitable result of those statutes, as their effect was to empower providers to compel MCOs to pay providers more for their services than if providers were forced to compete for the business of MCOs. John Miles, HEALTH CARE & ANTITRUST LAW: PRINCIPLES AND PRACTICE (Vol. 3, 2002) ("Miles") at App. D36-7; App. D33-8; and App. D32-7.

In each of the cited letters, the FTC emphasizes that AWP laws have anti-competitive effects that increase costs, specifically citing to economic studies which demonstrate that selective contracting practices by MCOs moderate health care cost increases. *Id.* at App. D36-4. In an important conclusion, the FTC emphasizes that:

> To the extent that opening programs to all providers reduces the portion of subscribers' business that each provider can expect to obtain, these providers may be less willing to enter agreements that contemplate lower prices or additional services. Moreover, since any provider would be entitled to contract on the same terms as other providers, there would be little incentive for providers to compete in developing attractive or innovative proposals. Because all providers can 'free ride'

6. FTC Staff Letter to the Attorney General of Montana Regarding "Any Willing Provider" Laws, February 4, 1993 (all providers); FTC Letter to the California State Senate Regarding "Any Willing Provider" Laws; June 26, 1992 (pharmacy providers); FTC Letter to the New Hampshire Senate Regarding "Any Willing Provider" Laws, March 17, 1992 (pharmacy providers).

> on a successful formulation, innovative providers may be unwilling to bear the cost of developing a proposal. Thus 'any willing provider' requirements may substantially reduce provider competition for this segment of their business.

Id. at D36-6. In an observation relevant to the always pertinent question, "Cui bono?" (who benefits?), the FTC points out that AWP laws limit consumer choice in the marketplace. *Id.* at D36-7. *See* note 5, *supra*. They have that effect because they deprive consumers of access to the less costly coverage option of a limited provider panel or network, with its lower costs of administration and greater ability to obtain volume discounts on fees and rates from providers. *Id.* MCOs certainly do not benefit from the impairment of their ability to contain costs. That leaves only the providers who gain anything from AWP laws. The protection of the income and financial well-being of health care providers by sheltering them from marketplace competition is not, and never has been, an aspect of the states' regulation of the business of insurance.

Nor can such protection of the economic interests of providers be justified on the basis of the state's interest in the regulation of health care policy. *Cf. New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656-662 (1995). There is no evidence in either the record of this case, or in documented peer reviewed studies, that the existence of closed panel health care coverage options in the marketplace has caused, or is likely to cause, a shortage of providers of any kind constituting a threat to the public welfare. As the FTC has pointed out:

> Indeed, by reducing their competitiveness with other kinds of third-party payment programs, requiring

> PPOs (preferred provider organizations constituting MCO selected and limited provider panels) to grant open participation may reduce the number, variety, and *quality* of prepayment programs available to consumers without providing any additional consumer benefit.

Miles at App. D36-7 (emphasis added). The term "PPO" is an acronym for "Preferred Provider Organization," a form of MCO network structure. *See* Weiner & de Lissovy, *Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. Health Politics, 75, 99 (1993). For the past twenty-five years, the FTC has supported the marketplace availability of selective MCO controlled provider panel health care coverage options. *See* Bureau of Economics, Federal Trade Commission, *Staff Report on the Health Maintenance Organization and its Effects on Competition* (1977). The FTC has brought enforcement actions against providers and provider associations when they have attempted to eliminate from the marketplace MCOs that utilize selective contracting and closed provider panels. Miles at App. at D-33-2.[7]

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7. The FTC hardly stands alone in its position that AWP laws are anti-competitive and anti-consumer. *See generally*, Fred J. Hellinger, *Any-Willing-Provider Laws and Freedom of Choice Laws: An Economic Analysis*, HEALTH AFF., Vol.14, Number 4 (1995); *National Anti-Managed Care Laws Would Raise Health Care Costs, Study Says*, 3 HEALTH CARE POLICY REP., (BNA) No. 26, at D-53 (June 26, 1995); *see* Andrew L. Jiranek & Susan Baker, *Any Willing Provider Laws*, 28 MD. B.J. 27, (1995); Jonathan E. Fielding & Thomas Rice, *Can Managed Competition Solve the Problems of Market Failure*, HEALTH AFF., Supp. 1993, at 216, 221; *Cf.* Thomas L. Greaney, *Competitive Reform in Health Care: The Vulnerable Revolution*, 5 YALE L.J. on REG. 179, 187-88 (1988).

C. AWP Laws Do Not Benefit the Purchasers of MCO Products and Services.

There is no documentation for the proposition that AWP laws provide any benefit or advantage to the actual recipients of the health care services covered by ERISA plans — i.e. Participants of such plans. AWP laws do not: (a) require coverage of additional benefits; (b) reduce co-payments or deductibles; (c) lower employees' share of premiums, or contributions in the case of self-funded plans, nor; (d) critically, create any authority or capacity the Participants may exercise to compel providers to join an MCO network. It also is the case that AWP laws confer no benefit or advantage upon the entities which bear the primary cost burden of funding ERISA health and welfare plans — employers.

In the context of ERISA plans, the purchasers of coverage (or benefit plan administration services in the case of self-funded plans) from MCOs normally are employers who provide health care coverage benefits to their employees and the employees' eligible dependents as well. *Fronstin*, pp. 1-2. The sole exception consists of the so-called "Taft-Hartley Trust" plans. 29 U.S.C. § 141, *et seq*. These trusts are jointly trusteed by management and labor and sponsor ERISA plans. 29 U.S.C. § 186(c)(5)(B). The funding for such trusts derives from employer contributions required by the terms of collective bargaining agreements between them and labor organizations. 29 U.S.C. §§ 186(c)(4) and (5). Both labor and management are united in their opposition to AWP laws as damaging to the interests of the Participants that they serve as fiduciaries.

In *Prudential Ins. Co. of America v. National Park Medical Center, Inc.*, 154 F.3d 812 (8th Cir. 1998), for example, labor unions (the AFL-CIO of Arkansas and the United Paperworkers International Union) joined with the largest private employer in Arkansas, which sponsored a self-funded ERISA health and welfare plan for its employees (Tyson Foods, Inc.), and MCOs (Prudential entities) to challenge Arkansas' AWP statute. Under Section 404 of ERISA, 29 U.S.C. § 1104, ERISA fiduciaries are subject to a duty to act solely and exclusively in the interests of the Participants of the plans they serve. If AWP laws conferred any benefit upon ERISA plan Participants that was not clearly outweighed by such laws' detrimental effects upon the interests of the Participants, ERISA plan fiduciaries would be obligated to support, not oppose, AWP laws. 29 U.S.C. § 1104(a)(1). There is no case to be found, however, to which an ERISA plan fiduciary is a party, where that fiduciary supported a state's AWP law.

The researchers who conducted the RWJF Study cited earlier[8] attempted to determine whether there was a discernable pattern among the states that enacted AWP laws and those states which were unlikely to enact such laws. *See supra*, National Program Reports, *Research on the Effects of Any-Willing Provider Laws*. The researchers "determined that states with greater numbers of health care providers were more likely to enact AWP laws . . . , while states with greater numbers of large employers were less likely to enact the laws." *Id.* at p. 2 of 4. In an intriguing finding, the researchers concluded that AWP laws are more likely to be enacted in states that have not experienced substantial MCO penetration. *Id.* AWP statutes thus are "preemptive" strikes by providers to prevent MCOs from bringing managed care practices into the state that would require providers to engage in price competition. *Id.*

8. *See* p. 14, *supra*.

Consistent with the conclusions of the RWJF Study researchers, the enactment of AWP legislation has been attributed to "state legislators' desires to placate 'a vocal and respected constituency' of health providers." Jordan, 27 ARIZ. L.J. at 916. State executives, however, who are responsible for meeting the healthcare cost burdens of Medicaid programs and benefits for public employees, are not at all enthusiastic about AWP laws. In July 1994, the National Governors' Association unanimously approved a policy to resist AWP legislation. Hellinger, HEALTH AFF., Vol. 14, No. 4 at 299; "*Any Willing Provider Legislation: Who's Pro, Who's Con, Who's on the Fence and Why*," HEALTH TECHNOLOGY ASSESSMENT NEWS (September-October 1994): 3.

The alignment of the political and economic interests in favor of and opposed to AWP laws is consistent with the unavoidable conclusion that such laws have nothing at all to do with the business of insurance. Their sole purpose and utility is to permit providers to engage in concerted activities that preclude to MCOs the ability to bargain with providers who have been evaluated and selected for inclusion in their networks for reasons of quality, acceptability to members, and reduced cost. AWP laws promote the very type of activity that the FTC has found to be anti-competitive, and for which it has successfully pursued remedial actions against providers and provider associations. *See Miles*, App. D36-4, 6-7.

D. AWP Laws are Preempted Because They Interfere With The Right and Ability of Employers and Plan Fiduciaries to Design ERISA Plan Benefits, and to Administer ERISA Plans Without Interference by the States.

When Congress enacted ERISA, it clearly intended to provide employers with wide latitude in deciding: (a) which health care coverage benefits they would provide to their employees;[9] and (b) how they would fund those benefits.[10] ERISA also was expressly designed to prevent the states from interfering with the administration of ERISA plans directly, or on a pretense that they constitute "insurance" subject to state supervision. 29 U.S.C. § 1144(b)(2)(B); *see, e.g.*, *FMC Corp. v. Holliday*, 498 U.S. 52, 60-65 (1990); *Medical Mutual of Ohio v. DeSoto*, 245 F.3d 561, 572-574 (6th Cir. 2001). The Sixth Circuit's decision disregards the clear intent of Congress in all of these respects.

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9. *See, e.g.*, 29 U.S.C. § 1001; ERISA leaves to private employers the authority to decide what health care benefits they will cover. *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996); *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 77-80, (1995) (". . . we are mindful that ERISA does not create any substantive entitlement to employer-provided health benefits or any other kind of welfare benefits . . ."); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90-91 (1983); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981); *Maez v. Mountain States Tel. and Tel.*, 54 F.3d 1488 (10th Cir. 1995); *McGann v. H & H Music Co.*, 946 F.2d 401 (5th Cir. 1991); *Hlinka v. Bethlehem Steel Corp.*, 863 F.2d 279 (3d Cir. 1988).

10. ERISA preempts state laws that mandate employee benefit structures or their administration. *See, e.g.*, *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995); *Texas Pharmacy Ass'n v. Prudential Ins. Co. of America*, 105 F.3d 1035 (5th Cir. 1997), *cert. denied* 522 U.S. 820 (1997); *Stone & Webster Engineering Corp. v. Ilsley*, 690 F.2d 323, 329 (2d Cir. 1982), *aff'd sub nom; Arcudi v. Stone & Webster Engineering Corp.*, 463 U.S. 1220 (1983).

First, the decision simply ignores the reality that Kentucky's AWP statute is applicable to self-insured ERISA plans that are administered by MCOs. Ky. Rev. Stat. § 304.17A-005(23). The statute is applicable without exception to all the activities and functions of MCOs. It thus sweeps into its scope ERISA self-funded plans whose only connection to an MCO is that they have retained the MCO to administer claims for which the plans alone, not the MCO, bear the risk of payment. As the MCO is not an insurer in that setting, the only basis on which it can be argued that there is a risk-shifting transaction that would constitute the "business of insurance" is if the transaction between the self-funded ERISA plan and its Participants is treated as the insurance transaction. That determination, however, is expressly proscribed to the states by ERISA's "Deemer Clause." 29 U.S.C. § 1144(b)(2)(B).

Second, Kentucky's AWP law effectively prevents self-funded ERISA plans from offering a health care coverage benefit that involves a limited, or selective, provider network, unless the plan itself undertakes to both create and to administer that network. The pragmatic reality, however, is that only the largest and most sophisticated employers and plans could undertake to create such a network, particularly on a multi-state basis. The circumstance that Kentucky's AWP law denies to self-funded ERISA plans the right or ability to access MCO networks, even when the MCO is not an insurer to the plan, without more and irrespective of the plan's ability to create its own provider network, is an interference with the plan's ability to decide how it wants to deliver covered benefits to its Participants. That constitutes proscribed state interference with ERISA plan design and administration. *See* notes 8 and 9, *supra*.

E. Kentucky's AWP Law is Not Saved from Preemption by ERISA'S Insurance Savings Clause.

The Court in its recent decision in *Rush Prudential HMO, Inc. v. Moran*, 536 __, No. 00-1021, slip op. (2002), ("Rush Prudential") affirmed the long-standing principle that ERISA's Insurance Savings Clause, 29 U.S.C. Sec. 1144(b)(2)(a), saves from ERISA's preemptive scope only a limited category of state laws. Such laws must satisfy, as a threshold test, the requirement that, as a "common-sense view of the matter," the state law regulates insurance. *Id.*, slip op. at 8 citing *Metropolitan Life Ins. v. Massachusetts*, 471 U.S. 724, 740 (1985). The Court, citing to its decision in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. at 211, confirmed that "the business of insurance" that is saved from ERISA preemption by the Savings Clause is "not coextensive with the 'business of insurers.' "

The first inquiry under the "common-sense" test focuses on " 'primary elements of an insurance contract [, which] are the spreading and underwriting of a policyholder's risk'. Id. at 211." Kentucky's AWP statute has absolutely no relationship or connection to any health care risk to which a policyholder may be exposed, which risk has been transferred to an MCO. The ability of a provider to force itself into an MCO's network does not result in creating new health risks to which the MCO's members are exposed, the liability for which has been transferred to the MCO. Thus, the core and indispensable characteristic of a state law that may be saved from preemption under the Savings Clause, that it effectuate the transfer of a risk from an insured to an insurer, simply does not exist in Kentucky's AWP statute.

The relationship affected by Kentucky's AWP statute, and all similar state statutes, is identical in every relevant respect to the relationship between the insurer and its pharmacy vendors in *Royal Drug*. The issues of "who" an insurer compensates for covered goods and, services, and "how much" the insurer may be obiigated to compensate such vendors only involves the "business of insurers," and is not "the business of insurance." As a result, Kentucky's AWP statute is not a state law covered by ERISA's Savings Clause, and it is not saved from preemption.

CONCLUSION

For the foregoing reasons, Amici AAHP, HIAA, NAM and BCBSA respectfully submit that the decision of the Sixth Circuit Court of Appeals should be reversed.

Respectfully submitted,

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KENTUCKY ASSOCIATION OF HEALTH PLANS, *et al.*,

Petitioners,

v.

JANIE MILLER, COMMISSIONER OF THE KENTUCKY DEPARTMENT OF INSURANCE,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

BRIEF FOR THE SOCIETY FOR HUMAN RESOURCE MANAGEMENT AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

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INTEREST OF AMICUS CURIAE[1]

The Society for Human Resource Management (SHRM) is the world's largest association devoted to human resource (HR) management. Founded in 1948, SHRM has more than 500 affiliated chapters within the United States and members in more than 120 countries. SHRM represents more than 170,000 individual members, ranging from HR managers to top HR executives. Its membership encompasses every industry and ranges from one-person consulting firms to Fortune 500 companies. SHRM is committed to advancing the HR profession and making HR an essential and effective partner in organizational strategy. It serves the needs of HR professionals by providing them with essential resources to perform their functions in every HR discipline, including benefits administration, employee relations and staffing.

SHRM prides itself on being an association of professionals concerned with the needs and interests of American workers. Its views are very close to those of the employees served by SHRM members. Thus, health care coverage and administration are matters of significant concern among SHRM's members, many of whom deal with benefits-related issues on a daily basis.

SHRM supports the orderly development of the law of employee benefits. SHRM encourages the voluntary adoption of employee benefit plans regulated by the

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[1] All parties in this case have submitted letters of consent for this brief to be filed, in accordance with S. Ct. Rule 37.3(a). Counsel for a party did not author this brief in whole or in part. No persons or entities other than the *Amicus Curiae*, its members or its counsel made a monetary contribution to the preparation or submission of this brief.

Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq*. One of the most attractive features of ERISA is the freedom it affords employee health benefit programs – especially those which are self-insured – by exempting them from state regulation. Preemption creates a strong incentive for employers to establish, customize and maintain employee health benefit plans. This incentive is particularly meaningful to employers that operate in multiple states. Many SHRM members are employed by employers that operate in a multi-state environment.

SHRM views ERISA preemption as a means of maintaining and improving health care now provided to American workers.

THE DECISION OF THE COURT OF APPEALS

This case addresses whether ERISA preempts Kentucky's "any willing provider" ("AWP") statute, which requires a health "insurer" to admit into its managed care network "any provider who is located within the geographical coverage of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer[.]" KY. REV. STAT. § 304.17A-270. The statute's definition of "insurer" is not a limited one, but rather expressly encompasses all that ERISA does not:

> any insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement *not exempt from state regulation by ERISA*; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky.

KY. REV. STAT. § 304.17A-005(23) (emphasis added).

In a 2-1 opinion, the Court of Appeals for the Sixth Circuit held that the statute "relates to" employee benefit plans governed by ERISA, *see Kentucky Assoc. of Health Plans, Inc., et al. v. Nichols*, 227 F.3d 352, 358-63 (6th Cir. 2000); 29 U.S.C. § 1144(a), but is saved from preemption because it is a law regulating the business of insurance, 227 F.3d at 363-72; 29 U.S.C. § 1144(b)(2)(A). The dissent agreed that the statute "relates to" ERISA plans, but reasoned that Kentucky's AWP statute does not regulate the business of insurance. *Id.* at 372-83.

SUMMARY OF ARGUMENT

ERISA health benefit plans account for the majority of American health coverage. Health costs are a dramatically increasing component of total employee compensation. Managed care networks (MCNs), utilized by many ERISA plans to provide cost-effective health coverage, are a grouping of medical providers who meet specific quality standards and receive a guaranteed volume of business from plan participants, in return for which the medical providers agree to fee discounts. ERISA plans use MCNs to provide quality health care at relatively low rates, and they are under attack by AWP statutes.

Any Willing Provider statutes like Kentucky's will undercut the cost-containment options available to ERISA health plans at a time when more, not less, cost control is

sorely needed. If MCNs are forced to accept more health care providers into their networks, they will lose bargaining power to control costs because the guaranteed volume per provider will decrease. The providers will negotiate higher fees to account for the reduced volume, and premiums for coverage will increase to pay these increased fees. The more expensive it is for employers to offer health benefits, the more likely they are to reduce benefits, or transfer money from benefits to the wage component of total employee compensation, in order to fix costs. Either way, most employees will become less insured, less healthy and less productive. ERISA preemption should be read to preclude state AWP laws and their associated costs to employees.

The ERISA preemption analysis should begin and end "by simply asking if state law conflicts with the provisions of ERISA or operates to frustrate its objects." *Boggs v. Boggs*, 520 U.S. 833, 841 (1997). The Congressional policy embodied in ERISA preempts Kentucky's AWP law because ERISA generally establishes and safeguards employer freedom to define the terms of ERISA plans and customize benefit plan design (especially self-insured plans) – without state intervention. The Kentucky AWP law contradicts this fundamental ERISA principle by limiting the availability of MCNs as health care delivery vehicles for ERISA plans. Kentucky's law also runs contrary to ERISA's policy of minimizing the administrative burden on employers – multi-state employers in particular – who sponsor health benefit plans. Upholding AWP laws like Kentucky's will force employers to structure and administer their plans on a state-by-state basis, which is "exactly the burden ERISA seeks to eliminate." *Egelhoff v. Egelhoff*, 532 U.S. 141, 151 (2001).

Kentucky's law does not regulate the business of insurance and is not therefore saved from preemption. The law fails to satisfy the common sense meaning of the business of insurance. The statute is *not* limited to entities within the insurance industry; rather, it purports to regulate all arrangements "not exempt from state regulation by ERISA." *See* KY. REV. STAT. § 304.17A-005(23).

Comprehensive federal health reform is a work in progress and an active part of the Congressional legislative agenda. At present, however, ERISA remains the last federal consensus on employee health benefit plans, and it represents a policy that gives plans the freedom to confront the health care cost crisis without state intervention. ERISA policy thus encourages employers to provide health benefits to their workers. The worst approach to the health care crisis would be the judicial abandonment of this policy by allowing states to undermine MCNs. The Court should reverse the decision below, hold that Kentucky's AWP statute is preempted by ERISA, and preserve the ability of employers to administer cost-effective ERISA health plans through MCNs, without state intervention.

ARGUMENT

I. ERISA HEALTH PLANS USE MCNs AS THEIR PRINCIPAL METHOD OF COST CONTAINMENT.

Employer-sponsored health plans, which are voluntarily adopted by employers, account for the majority of Americans' health insurance. In 2000, approximately 67 percent of the United States population under age 65 (163.4 million Americans, including 46 million children)

received health care coverage from an employer-sponsored health plan. *See* Paul Fronstin, *Number of Americans with Job-Based Health Benefits Increased in 2000 While Uninsured Declined*, EMPLOYEE BENEFIT RESEARCH INSTITUTE NEWSLETTER, vol. 22, No. 11, November 2001, at 1-2. The percentage of American workers enrolled in employer-sponsored managed care plans, moreover, has increased from 27 percent in 1988 to 93 percent in 2001. KAISER FAMILY FOUNDATION, TRENDS AND INDICATORS IN THE CHANGING MARKETPLACE, MAY 2002 CHARTBOOK 17 (citations omitted), *available at* http://www.kff. org [hereinafter TRENDS AND INDICATORS].

MCNs provide quality health care and control costs by grouping together select medical providers who meet specific standards and receive a guaranteed volume of business from managed care plan participants. In return, the providers agree to discount their fees. MCNs aim to guarantee plan participants access to all necessary health care through a network. To encourage participants to use network providers, participants pay more for non-emergency treatment obtained from a non-network provider.

Employers who self-insure their health plans contract with MCNs to make available the MCN's network of providers. An employer who sponsors a self-insured plan typically pays the employees' health benefit claims out of its general assets as claims are incurred. Under such an arrangement, the employer bears the financial risk associated with its employees' health care expenses. *See* U.S. General Accounting Office, GAO/HEHS-95-167, *Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA* at 3 & n.2 (1995). Thus, MCNs represent at

present the key operating delivery vehicle providing health care for American workers.

II. ABSENT ERISA PREEMPTION OF STATE AWP LAWS, ERISA PLANS WILL HAVE FEWER MCNs WITH WHICH TO CONTRACT, AND WILL INCUR HIGHER HEALTH COSTS.

Since the time of the first health care crisis in the early 1990s, employers have experimented with health plan cost control methods in order to continue offering health benefits. Premiums for the traditional "fee for service" indemnity health plans increased 18 percent in 1989 alone. *See* TRENDS AND INDICATORS at 28 (citations omitted), *available at* http://www.kff.org. These increases were due in part to patient demands for, and physician acquiescence to, unnecessary tests or procedures – a practice that went virtually unchecked in indemnity plans.

Managed care then emerged, and to date it remains the best hope to contain health care costs (as evidenced by the fact that 93 percent of employees receiving employer-sponsored health benefits were enrolled in a managed care plan in 2001, *see* TRENDS AND INDICATORS at 17 (citations omitted), *available at* http://www.kff.org). Even so, the cost of health benefits has steadily increased. Overall health insurance expenses increased 8.3 percent between 1999 and 2000, 11 percent between 2000 and 2001, and 12.7 percent between 2001 and 2002. THE KAISER FAMILY FOUNDATION AND HEALTH RESEARCH AND EDUCATIONAL TRUST, EMPLOYER HEALTH BENEFITS 2002 ANNUAL SURVEY 14 (citations omitted), *available at* http://www.kff.org. For

employer-sponsored plans that offer HMO benefits, initial 2003 HMO rates (pre-negotiation) are increasing at an average of 22 percent. *HMO Rates Continue to Rise at Double Digit Pace*, HEWITT ASSOCIATES PRESS RELEASE, *available at* http://www.hewitt.com.

To combat rising costs, some employers have shifted expenses to their employees by increasing employees' premium contributions, deductibles or co-payments. BNA, Inc., *Rising Health Care Costs Prompt Myriad Initiatives*, BNA HEALTH CARE POLICY REPORT, vol. 10, no. 8 at 303-04 (Feb. 25, 2002); BNA, Inc., *Rising Health Care Costs Prompt Myriad Initiatives*, BNA BULLETIN TO MANAGEMENT, vol. 53, no. 7, Part 2 at S1-S3 (Feb. 14, 2002); *see also Hughes v. 3M Retiree Medical Plan*, 281 F. 3d 786, 791-93 (8th Cir. 2002) (holding employer did not violate ERISA by increasing premiums for retiree medical benefits). Others have cut back health benefits or even eliminated them altogether – particularly for retirees. *See, e.g., Sprague v. General Motors Corp.* 133 F.3d 388, 399-406 (6th Cir. 1998) (*en banc*) (rejecting retirees' claims under ERISA to enforce "lifetime" health benefits after benefits were altered).

If MCNs are forced by the states to accept more health care providers into their networks, they will lose bargaining power in negotiating with providers to join or remain affiliated with a network because the number of guaranteed patients will decrease per provider. The AWP laws certainly will interfere with the ERISA plan's relationship with MCNs. As a result, the networks will become more expensive and less pervasive. *See Recent Legislation*, 109 HARV. L. REV. 2122, 2125 (1996); *see also* TRENDS AND INDICATORS at 55 (setting forth, for each state as of 2000,

number of physicians per 100,000 population) (citations omitted), *available at* http://www.kff.org. Ultimately, the networks may disappear.

AWP-related health plan cost increases will directly affect all ERISA plans, including self-insured plans, that rely on the networks to deliver care to plan participants. Indeed, these laws severely limit – and threaten to eliminate altogether – an entire category of plan design options for employer-sponsored health plans. The end result may be that employers, faced with greater challenges in maintaining an affordable health plan, may choose to reduce the availability of health benefits, completely alter the structure of such benefits, or eliminate them altogether. *See Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 11 (1987) (noting that administrative burdens resulting from no preemption could cause "those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them"). Employers may even lay off employees to compensate for the increased health costs, thus adding to the ranks of the uninsured, underinsured and unemployed. *See* Milt Freudenheim, *Next Big Health Debate: How to Help Uninsured*, N.Y. TIMES, Aug. 27, 2002, at Section C, p.1; Robin Toner and Sheryl Gay Stolberg, *Decade After Health Care Crisis, Soaring Costs Bring New Strains*, N.Y. TIMES, Aug. 11, 2002, at Section 1, p.1 (noting that "Families USA, a consumer advocacy group, has estimated that more than two million Americans lost their insurance last year because of layoffs").

Another possibility is that employers may alter the structure of their benefit plans by allocating a fixed allowance of money per year to cover medical expenses regardless of need. *See generally* I.R.S. Notice 2002-45,

2002-28 I.R.B. 93. Once an employee's health care expenses surpass her allowance, she may become responsible for *all* additional medical expenses. Employees may perceive this structure as a reduction in benefits, which could negatively affect employee morale (and thus reduce productivity) and public perception of the employer (and thus reduce employer profits). *See* Phyllis C. Borzi, *Are Defined Contribution Health Plans the Silver Bullet?* at Part III, *available at* http://www.abanet.org. Such plans may not provide employees with the "best value for their health care dollars without the leverage that an employer-purchaser provides." *Id.* These plans also may leave older or sicker employees, particularly those with chronic illnesses, in a bind because once those employees surpass their employer-provided allowance, they may have difficulty finding coverage in the individual health plan marketplace. *Id.*

Allowing state regulation that undermines MCNs is a step backwards. ERISA preemption questions have "generated an avalanche of litigation in the lower courts." *DeBuono v. NYSA-ILA Medical and Clinical Serv. Fund*, 520 U.S. 806, 808 n.1 (1997) (citation omitted); indeed, this Court has decided eight ERISA preemption cases in the past decade alone.[2] The Court should protect the most

[2] *See Rush Prudential HMO, Inc. v. Moran*, 122 S. Ct. 2151 (2002); *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001); *UNUM Life Insurance Co. v. Ward*, 526 U.S. 358 (1999); *California Div. of Labor Standards Enforcement v. Dillingham Const., N.A., Inc.*, 518 U.S. 1053 (1997); *Boggs*, 520 U.S. 833; *DeBuono*, 520 U.S. 806; *New York State Conference of Blue Cross & Blue Shields Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995); *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125 (1992).

effective and only proven remaining cost savings method – MCNs – until Congress develops a new health care consensus. *Cf. Pegram v. Herdrich*, 530 U.S. 211, 221 (2000) (the legislature is the "preferable forum for comprehensive investigations and judgments of social value, such as optimum treatment levels and health care expenditure") (internal citations omitted).

III. THE DECISION OF THE COURT OF APPEALS FOR THE SIXTH CIRCUIT CONFLICTS WITH THE FEDERAL POLICY EMBODIED IN ERISA.

Congressional policy embodied in ERISA favors preemption of Kentucky's AWP law. Congress established as federal policy in the ERISA welfare benefit plan context that employers must be free to define plan terms, in their sole judgment, on the theory that substantive benefit mandates would discourage the establishment of welfare plans with attractive benefits.[3] The House Ways and Means Committee that approved ERISA offered this explanation of the need in ERISA for a careful balance of employee protection and employer flexibility:

> Generally, it would appear that the wider or more comprehensive the coverage, vesting, and funding, the more desirable it is from the standpoint of national policy. However, since these plans are voluntary on the part of the employer

[3] To compensate for this freedom, Congress provided employees with a cause of action (regardless of the satisfaction of common law contract elements) for breach of the voluntarily chosen plan terms. *See* § 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B).

> and both the institution of new pension plans and increases in benefits depend upon employer willingness to establish or expand a plan, it is necessary to take into account additional costs from the standpoint of the employer. If employers respond to vesting and funding rules by decreasing benefits under existing plans or slowing the rate of formation of new plans, little if anything would be gained from the standpoint of securing broader use of employee pensions and related plans. . . .

H.R. REP. No. 93-807, at 15 (1974), *reprinted in* 1974 U.S.C.C.A.N. 4670, 4682.

The manner in which ERISA plans are structured – by MCNs, traditional indemnity arrangements or otherwise – are matters within the sole discretion of the plan sponsor. *See Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996) ("Nothing in ERISA requires employers to establish employee benefits plans. Nor does ERISA mandate what kind of benefits employers must provide if they choose to have such a plan.") (citations omitted); *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995) ("ERISA does not create any substantive entitlement to employer-provided health benefits or any other kind of welfare benefits. Employers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans.") (citations omitted); *Moore v. Reynolds Metals Co. Retirement Program*, 740 F.2d 454, 456 (6th Cir. 1984) ("Neither Congress nor the courts are involved in either the decision to establish a plan or in the decision concerning which benefits a plan should provide").

To preserve this discretion and encourage employers to offer benefit plans voluntarily, ERISA preempts state laws that relate to ERISA plans, such as those which "mandate[ ] employee benefit structures or their administration." *Travelers*, 514 U.S. at 657-58 (summarizing certain state laws held preempted); *accord Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524 (1981) (holding that state law was preempted by ERISA because it "eliminates one method for calculating pension benefits . . . that is permitted by federal law"); 29 U.S.C. § 1144(a).

The Court has summarized Congress's underlying purpose for enacting ERISA's broad preemption clause:

> An employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements. The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursements of benefits.

Fort Halifax, 482 U.S. at 9. Indeed, the legislative history of ERISA characterizes ERISA's preemption clause as "the reservation to Federal authority [of] the sole power to regulate the field of employee benefit plans." 120 CONG. REC. 29197 (1974) (statement of Rep. Dent). Congress preserved especially broad freedom for self-insured employers to structure their benefits as they deem appropriate by exempting self-insured plans from state insurance regulation. *See FMC v. Holliday*, 498 U.S. 52, 61 (1990)

("[S]elf-funded ERISA plans are exempt from state regulation insofar as that regulation 'relates to' the plans.").

The ERISA preemption analysis should begin and end "by simply asking if [the] state law conflicts with the provisions of ERISA or operates to frustrate its objects." *Boggs*, 520 U.S. at 841. Preemption applies if the "state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Id.* at 844 (citation and quotation marks omitted).

The Kentucky AWP law contradicts this fundamental ERISA policy by severely limiting the delivery of medical care through MCNs as a method of structuring health benefits. The Kentucky AWP law mandates that MCNs include "any provider . . . who is willing to meet the terms and conditions for participation established by the health insurer." KY. REV. STAT. § 304.17A-270. *Cf. CIGNA Health Plan of La., Inc. v. Ieyoub*, 82 F.3d 642, 648 (5th Cir. 1996) (holding that Louisiana AWP statute "related to" ERISA plans under § 514(a) of ERISA because the statute "den[ied] insurers, employers, and HMOs the right to structure their benefits in a particular matter . . . effectively requiring ERISA plans to purchase benefits of a particular structure").

These state laws also interfere with another fundamental purpose of ERISA: "eliminating the threat of conflicting and inconsistent State and local regulation," 120 CONG. REC. 29197 (1974) (statement of Rep. Dent), and thus minimizing the administrative burden on employers – multi-state employers in particular – who sponsor health benefit plans. Upholding AWP laws like Kentucky's will force employers to learn the ins and outs of different state laws, and structure and administer their

plans on a state-by-state basis. In other words, these laws require "tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction" – which is "exactly the burden ERISA seeks to eliminate." *Egelhoff*, 532 U.S. at 151; *see also id.* at 149-50 ("Requiring ERISA administrators to master the relevant laws of 50 States and to contend with litigation would undermine the congressional goal of 'minimiz[ing] the administrative and financial burden[s]'on plan administrators – burdens ultimately borne by the beneficiaries.") (citing *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)).[4]

In short, Kentucky's AWP statute "stands as an obstacle to the accomplishment of the full purposes and objectives of Congress" in enacting ERISA, *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99 (1993) (citation and quotation marks omitted), because it undermines the principal cost control tool of ERISA health plans and imposes significant administrative burdens on employers who sponsor those plans. *See also Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 56 (1987) (the ERISA scheme "would make little sense" if the states can tinker with it).

[4] The majority below opined that Kentucky's AWP statute would not apply to HMOs providing purely administrative services for self-insured ERISA plans because the statute applies "only to health insurers." 227 F.3d at 367 n.14. The statute, however, unquestionably undercuts MCNs acting in *any* capacity, which in turn directly restricts the ability of ERISA self-insured plans to control benefit costs.

IV. GIVEN THE BREADTH OF ERISA PREEMPTION, NONE OF ITS EXCEPTIONS, INCLUDING THAT FOR "ANY STATE LAW THAT REGULATES INSURANCE," SHOULD BE GIVEN THE EXPANSIVE READING OF THE COURT OF APPEALS.

ERISA's savings clause exempts from ERISA preemption state laws that regulate insurance from a "common sense" point of view. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740 (1985); 29 U.S.C. § 1144(b)(2)(A). The Court then tests the result of the common sense inquiry by considering the three factors used to identify insurance law spared from federal preemption under the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq*. *Moran*, 122 S. Ct. at 2159. These factors address (1) whether the law "has the effect of transferring or spreading a policyholder's risk," *Metropolitan Life*, 471 U.S. at 743 (citing *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)); (2) whether the law affects "an integral part of the policy relationship between the insurer and the insured," *id.*; and (3) whether the law "is limited to entities within the insurance industry," *id.*

A. The Kentucky AWP Statute Does Not Regulate The Business Of Insurance From A "Common Sense" Perspective.

To regulate insurance from a "common sense" perspective, it is insufficient for a state law to "have an impact on the insurance industry." *Pilot Life*, 481 U.S. at 50. Rather, a state law meets this requirement if it "is directed specifically at the insurance industry and is applicable only to insurance contracts." *UNUM*, 526 U.S. at 368. The Court has consistently recognized that the "business of insurance" is

not coextensive with the "business of *insurers*." *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211 (1979), *cited in Moran*, 122 S. Ct. at 2159 (emphasis added).

The majority below failed to make this distinction. Instead, the majority focused on the fact that Kentucky's AWP statute applies to "insurers," *Kentucky Assoc. of Health Plans*, 227 F.3d at 361 – even though the statute's definition of "insurers" extends far beyond the "insurance industry" (*see infra* Part IV.B). The majority also relied on the expedient decision of the Kentucky legislature to codify its AWP statute within Kentucky's state insurance code. *Id.*

The majority's conclusion oversimplifies the "common-sense" inquiry because it fails even to examine what the AWP law regulates. As the dissent correctly pointed out, the Kentucky AWP law is "directed at the contracts between benefit plans and third parties, rather than being specifically directed at the insurance industry." 227 F.3d at 373 (citing *Pilot Life*, 481 U.S. at 50) (internal parenthetical omitted). Indeed, the statute's real focus is "regulating provider access to networks rather than specifically regulating the business of insurance." *Id.* at 375. Kentucky's AWP statute fails to satisfy the "common sense" test for regulating insurance.

B. The Kentucky AWP Statute Fails To Meet Any Of The McCarran-Ferguson Factors For Regulating The Business Of Insurance.

SHRM concurs with Petitioner's position that the AWP statute meets none of the McCarran-Ferguson

business of insurance factors, and comments only on the third – whether the law is limited to entities within the insurance industry.

Far from being "limited" to entities within the insurance industry, the statute attempts to reach virtually any entity involved in the delivery of health benefits. Indeed, the statute defines "insurer" to include "*any* . . . self-insurer . . . *not exempt from state regulation by ERISA*." KY. REV. STAT. § 304.17A-005(23) (emphasis added).

The language "not exempt from state regulation" shows an intent to regulate ERISA plans as much as possible, whether or not limited to the insurance industry. Any state law that purports to regulate insurance with language targeting self-insured plans, moreover, cannot possibly be said to be "limited" to the business of insurance.

The scope of Kentucky's AWP law thus lacks the limits of the state law recently considered in *Moran*. In *Moran*, the Court determined that Illinois' HMO Act, which provided HMO plan participants with a right to independent medical review of certain benefit denials, was saved from ERISA preemption because it regulated the business of insurance. 122 S. Ct. at 2156, 2163-64. Unlike the Kentucky statute, the Illinois Act was limited to HMOs, defined as "any organization . . . [which] provide[s] or arrange[s] for one or more health care plans under a system which causes any part of the risk of health care delivery to be borne by the organization or its providers." *Id.* at 2157 (citing 215 Ill. Comp. Stat., ch. 125, § 1-2). This Court thus concluded that the Illinois

Act met the third McCarran-Ferguson factor. *Id.* at 2163, 2164. The same cannot be said about the Kentucky statute at issue.[5]

V. THERE IS NO GOOD REASON IN THIS CASE TO IGNORE THE CENTRAL POLICY OF ERISA AND NOT TO ERR ON THE SIDE OF PREEMPTION.

Congress has not yet reached any consensus on a fundamentally new national health care policy to replace ERISA's objective of encouraging employers to offer health benefits to employees on a voluntary basis. Since the passage of ERISA nearly 30 years ago, there have been many attempts to overhaul the federal health care system, including, *e.g.*, President Clinton's proposed Health Security Act (HSA), H.R. 3600, 103d Cong. (1993); S. 1757, 103d Cong. (1993), and the proposed Managed Competition Act of 1993 (MCA), H.R. 3222, 103d Cong. (1993), both of which provided for an employer-based system of health

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[5] The Illinois Act in *Moran* is also distinguishable from the Kentucky AWP statute because the Illinois Act regulated "an integral part of the policy relationship between the insurer and the insured." *Moran*, 122 S. Ct. at 2163 (quotation marks omitted). The Illinois Act provided "a legal right to the insured, enforceable against the HMO, to obtain an authoritative determination of the HMO's medical obligations." *Id.* at 2164. In contrast, the Kentucky Act regulates the relationship between the insurer and third parties (medical providers). The AWP statute "[does] not force the insurer to offer a benefit to insureds that was not available before the law. Rather, Kentucky's AWP laws merely force insurers to potentially make additional contractual arrangements with providers they might otherwise exclude." *Kentucky Assoc. of Health Plans*, 227 F.3d at 383 (Kennedy, J., dissenting).

coverage, but were not enacted. Congress also has considered and rejected, tabled or abandoned many broad-based proposals to amend ERISA to narrow the scope of its preemption provisions. *See, e.g.*, H.R. 2723, 106th Cong. (1999) (proposing to amend ERISA to allow lawsuits against health plans or insurers under state law); S. 6, 106th Cong. (1999) (same); H.R. 1415, 105th Cong. (1997) (proposing to amend ERISA's preemption provisions to allow state-law causes of action to recover damages for personal injury or wrongful death); S. 794, 102d Cong. (1991) (proposing to save from preemption state laws providing remedies against insurance companies who administer employee benefit plans).

When Congress *has* chosen to address health care, it has acted incrementally. *See, e.g.*, the continuation health coverage requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), added to ERISA in 1986, 29 U.S.C. § 1161 *et seq.*; the portability and non-discrimination requirements of the Health Insurance Portability and Accountability Act (HIPAA), added to ERISA in 1996, 29 U.S.C. § 1181 *et seq.*; the minimum hospital stay requirement of the Newborns' and Mothers' Health Protection Act, added to ERISA in 1996, 29 U.S.C. § 1185; the requirements of the Mental Health Parity Act, added to ERISA in 1996, 29 U.S.C. § 1185a; and the requirements of coverage for reconstructive surgery following mastectomy as set forth in the Women's Health and Cancer Rights Act, added to ERISA in 1998, 29 U.S.C. § 1185b. Likewise, when Congress *has* chosen to allow state experimentation, it has acted specifically and incrementally. *See, e.g*, ERISA § 514(b)(6) (multi-employer welfare arrangements); (b)(7) (qualified domestic relations orders and qualified medical child support orders); (b)(8)

(states' rights to acquire COBRA rights of indigents); and (b)(9) (narrow exemption permitting states to establish more protective pre-existing condition rules in 29 U.S.C. § 1191). *See* 29 U.S.C. § 1144(b)(6) – (b)(9).

Overall policy for employer-sponsored health care emanates from ERISA, until Congress tells us otherwise. Until a new federal consensus is reached and enacted into law, it is not for the Court to abandon ERISA's policy favoring uniform employer freedom to control health costs without state intervention in their creative solutions, especially in the context of self-insured plans. Until a new federal consensus is reached and enacted into law, it would be a mistake to allow states like Kentucky to undermine the current and widespread reliance by ERISA plans on MCNs to deliver health care to American workers. As the Court of Appeals for the Eighth Circuit has recognized, "it is for Congress, not the courts, to reassess ERISA in light of modern insurance practices and the national debate over health care." *Prudential Ins. Co. of America v. National Park Med. Ctr.*, 154 F.3d 812, 830 (8th Cir. 1998) (citations omitted).

CONCLUSION

SHRM requests that the Court reverse the decision below, hold that Kentucky's AWP statute is preempted by ERISA, and preserve employers' ability to design health

plans to provide quality benefits at the least possible cost to American workers.

Respectfully submitted,

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In the
Supreme Court of the United States

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., ET AL.,
Petitioners,

v.

JANIE MILLER, COMMISSIONER OF THE KENTUCKY DEPARTMENT OF INSURANCE,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF OF THE STATES OF TEXAS, CALIFORNIA, CONNECTICUT, DELAWARE, FLORIDA, HAWAII, ILLINOIS, KENTUCKY, MARYLAND, OKLAHOMA, UTAH AND WEST VIRGINIA, AND THE COMMONWEALTH OF PUERTO RICO AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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QUESTION PRESENTED

Are state "Any Willing Provider" statutes preempted by ERISA, or are they saved from preemption because they are laws "which regulate insurance"?

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INTEREST OF THE *AMICI CURIAE*

The state *amici curiae*, through their Attorneys General, submit this brief in support of Kentucky Department of Insurance Commissioner Janie Miller. States have a vital interest in ensuring that the scope of preemption by the Employee Retirement Income Security Act of 1974 (ERISA) is not extended beyond Congress' intent. The text of ERISA and decisions of this Court evidence that Congress intended to reserve powers to the States. Specifically, the ERISA insurance saving clause, 29 U.S.C. § 1144(b)(2)(A), preserves the States' authority to regulate insurers. Last Term this Court again affirmed that health maintenance organizations (HMOs) are insurers subject to state insurance regulation. *Rush Prudential v. Moran*, 122 S.Ct. 2151, 2163 (2002). Petitioner HMOs[1] attempt to distinguish between insurance laws regulating benefits (which supposedly can be saved) and laws regulating an insurers' other activities (which supposedly cannot be saved). The HMOs base that strained dichotomy on *Group Life and Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979)—an antitrust case. In doing so, they mistakenly equate the "business of insurance" antitrust exemption with ERISA's preservation of laws which "regulate insurance." Their argument contradicts this Court's decisions holding the McCarran-Ferguson factors to be guideposts. *See Rush*, 122 S.Ct. at 2163; *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 373 (1999). Accordingly, the Sixth Circuit's decision should be affirmed.

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[1] Petitioners are a Kentucky-based association of HMOs and several individual HMOs. They are referred to herein simply as "the HMOs."

SUMMARY OF ARGUMENT

This Court's precedents directly proscribe the narrow saving clause test that the HMOs advance. In *UNUM Life Insurance Co. of America v. Ward*, 526 U.S. 358 (1999), this Court unanimously held that the ERISA saving clause saves California's common-law notice-prejudice rule. This Court rebuffed UNUM's claims that the rule did not spread risk. Nevertheless the HMOs now claim that a law must spread risk to qualify as an *insurance practice* that comes within the saving clause. Pet. Br. at 17. That argument defies common sense and imposes the first McCarran-Ferguson factor as a litmus test—which this Court has already rejected.

Essentially, the HMOs engraft a dichotomy between laws regulating insurance benefits and laws regulating insurers' other activities. They assert that the former are insurance practices that can be saved, while the latter are beyond the scope of insurance regulation, as that term is defined in the saving clause. Interestingly, that argument is the exact opposite of the argument Metropolitan Life advanced in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985). There, Metropolitan Life claimed that only state laws that directly regulate insurers and their business activities come within the ERISA saving clause. The Court rejected Metropolitan Life's narrow reading. The HMOs' narrow reading in this case should likewise be rejected.

Finally, the HMOs contend that *Group Life and Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), directs that Kentucky's Any Willing Provider law

cannot be saved. That argument incorrectly limits the ERISA saving clause to the McCarran-Ferguson antitrust exemption. But the text and the purposes of those two laws are different. This Court should again affirm that the McCarran-Ferguson factors are relevant guideposts—not a rigid test that must be met as the HMOs contend. The Sixth Circuit's decision should be affirmed.

ARGUMENT

A. The Narrow Reading of the ERISA Saving Clause that the HMOs Advance Ignores this Court's Precedents.

The Sixth Circuit correctly held that Kentucky's Any Willing Provider (AWP) law regulates insurance and, consequently, is saved from ERISA preemption.[2] The Circuit's analysis correctly asked first whether Kentucky's law regulates insurance from a "common sense view of the matter" and only then "consider[ed] three factors . . . used in the McCarran-Ferguson Act." *Ky. Ass'n of Health Plans,*

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[2] The state *amici* have not addressed the application of the three McCarran-Ferguson factors to Kentucky's AWP law because they agree with the Respondent and the majority of the circuits that AWP laws meet at least two of the three factors. *See Stuart Circle Hosp. Ass'n v. Aetna Health Mgmt.*, 995 F.2d 500, 502–04 (4th Cir. 1993) (holding Virginia's law saved); *Tex. Pharmacy Ass'n v. Prudential Ins. Co. of Am.*, 105 F.3d 1035, 1038 (5th Cir. 1997) (holding, pre-*Ward*, Texas's AWP law preempted because it meets two of the three McCarran-Ferguson factors).

Inc. v. Nichols, 227 F.3d 352, 363 (2000) (quoting *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 367–68 (1999)). The HMOs challenge that the Sixth Circuit reads the ERISA saving clause too broadly and that this Court's guidance is not so clear.

The HMOs contend that the ERISA saving clause is only meant to save a sliver of state insurance regulation—those laws aimed at *insurance practices*, but not those laws regulating insurers' other activities. Pet. Br. at 13 (emphasis in original). Inventively, they suggest that the common-sense test saves state laws only when those laws regulate the spreading and underwriting of a policyholder's risk. *Id.* at 30 n.13. Moreover, in direct contradiction to this Court's precedents, the HMOs argue that the McCarran-Ferguson Act is a litmus test[3] rather than a "guidepost" for determining when the ERISA saving clause save state insurance regulations. *Id.* at 13. These arguments run afoul of this Court's precedents and gloss over the substantive distinctions between the McCarran-Ferguson Act and ERISA.

[3] The "guidepost" factors are whether the law spreads risk, is an integral part of the policy relationship, and is limited to entities within the insurance industry. *See Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982) (involving whether a health insurer's use of a peer-review committee was exempt from federal antitrust laws).

1. ERISA's Initial Common-Sense Test Does Not Exempt HMOs and other Insurers from Following State Insurance Regulations.

Although the ERISA express-preemption clause, 29 U.S.C. § 1144, snuffs out laws that "relate to" employee benefit plans, Congress expressly saved state insurance laws from that preemptive force. In almost antithetically broad language, Congress provided that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. §1144(b)(2)(A). Through this provision, Congress expressed its intent that States continue to exercise their traditional powers in the field of insurance. Regardless whether a state statute "relates to" an ERISA plan, the "ERISA plan is . . . bound by state insurance regulations insofar as they apply to the plan's insurer." *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990).

Faced with the "unhelpful" language in these two clauses, this Court has recently reaffirmed the starting presumption that Congress intended to not supplant the historic police powers of the States. *Rush*, 122 S.Ct. at 2159; *see also New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995); *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 331–32 (1997); and *DeBuono v. NYSA-ILA Med. & Clinical Serv. Fund*, 520 U.S. 806, 814 (1997). Where, as here, Congress expresses its intent to save from preemption state laws that regulate insurance, there is

no basis to impose a restrictive interpretation of the clause. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S.724, 745 (1985). A narrow, artificial reading of the term "regulates insurance" would be inconsistent with that intent, and finds no support in the language of the saving clause or ERISA generally.

In *Metropolitan Life*, the Court rejected a narrow interpretation of the savings clause. 471 U.S. at 745. Rather, this Court took a "common-sense" view of the term "regulates insurance" in determining whether a state law is saved from ERISA preemption. 471 U.S. at 740. The issue as defined by this Court, is not whether a particular state law meets specific criteria, but whether the law regulates an insurance relationship, insurance contract or insurer. Such laws are at the "core of the insurance business." *Sec. & Exch. Comm. v. Nat'l Sec., Inc.*, 393 U.S. 453, 460 (1969).

In an interesting juxtaposition to this case, Metropolitan Life argued in the *Metropolitan Life* case that only state laws that directly regulate insurers and their business activities come within the ERISA saving clause—the mirror-opposite stance taken by the HMOs in this case. 471 U.S. at 741. Metropolitan Life claimed that state laws regulating the substantive terms of an insurance contract were recent innovations more properly seen as health laws and, therefore, outside the scope of the saving clause. *Id.* This Court, however, rejected Metropolitan Life's distinction because it "reads the saving clause out of ERISA entirely." *Id.*

Thus, in *Metropolitan Life*, 471 U.S. at 740, this Court held that a state law mandating that insurance companies provide certain coverages "regulates insurance" as a matter of common-sense and was thus saved from preemption. This Court reasoned that the state mandated-benefit law was a law regulating the terms of an insurance contract and that Congress expressly reserved the regulation of insurance contracts to the States. In determining whether Congress intended for laws regulating insurance contracts to be within the scope of laws preserved by the saving clause, this Court referred to the deemer clause.

The "deemer clause" states that an employee-benefit plan should not be deemed to be an insurance company "for purposes of any laws of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies or investment companies." 29 U.S.C. §1144(b)(2)(B). This Court reasoned that "[b]y exempting from the saving clause laws regulating insurance contracts that apply directly to benefit plans, the deemer clause makes explicit Congress' intention to include laws that regulate insurance contracts within the scope of the insurance laws preserved by the saving clause." *Metropolitan Life*, 471 U.S. at 71. The reference to insurance companies in the deemer clause makes equally clear Congress' intent to save from preemption state laws that regulate insurers.[4]

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[4]The Court implicitly recognized this in *Metropolitan Life* when it discussed examples of laws that regulate insurers. *Metropolitan Life*, 471 U.S. at 728, n.2.

Likewise, in *UNUM Life Insurance Co. of America v. Ward*, 526 U.S. 358 (1999), this Court held that California's notice-prejudice rule regulated insurance and was saved from ERISA preemption. 526 U.S. at 368. This Court observed that the California rule was directed specifically at insurers and their contracts. *Id.* (citing *Cisneros v. UNUM Life Ins. Co. of Am.*, 134 F.3d 939, 945 (9th Cir. 1998) (the common-law rule "is directed specifically at the insurance industry and is applicable only to insurance contracts.")). The unanimous Court highlighted that the McCarran-Ferguson Act "guideposts" are "relevant" "considerations [to be] weighed" in determining whether a state law regulates insurance. 526 U.S. at 373–74 (citations omitted). But the McCarran-Ferguson factors were never intended to form a litmus test for the saving clause's applicability.

Furthermore, this Court unanimously upheld California's notice-prejudice rule without analyzing whether California's rule spread risk. *Ward*, 526 U.S. at 374. Saying flatly, "[w]e need not pursue this point," this Court found the common-law rule to be a common-sense insurance regulation that met the two other McCarran-Ferguson factors. Arguing that the spreading and underwriting of a policyholder's risk is necessary to qualify as a common-sense insurance regulation flies in the face of this Court's unanimous decision in *Ward*. *See* Pet. Br. at 30 n.13 (asserting that *Rush* and *Royal Drug* "make clear" that the common-sense inquiry requires that "a law is saved from preemption if and only if it is regulating an *insurance* practice," which "are the spreading and underwriting of a policyholder's risk."). Moreover, that argument suggests that administrative

regulations, like the notice-prejudice rule in *Ward*, solvency requirements, and other enforcement regulations fall outside the ERISA saving clause because they do not spread risk between the insurer and the insured. In the final analysis, the HMOs argue that state laws regulating insurance benefits can be saved, but that state laws regulating insurers' other activities cannot.

That argument simply defies common sense. Without doubt, HMO subscribers believe they have health insurance.[5] The subscribers, or their employer, pay money to an HMO and, in return, expect to receive medical treatment when such treatment is necessary. *See Pegram v. Herdrich*, 530 U.S. 211, 218 (2000). Common sense tells these subscribers that they have health insurance. *See Washington Physicians Serv. Ass'n v. Gregoire*, 147 F.3d 1039, 1046 (9th Cir. 1998) ("In the end, HMOs function the same way as a traditional health insurer: The policyholder pays a fee for a promise of medical services in the event that he should need them. It follows that HMOs (and HCSCs) are in the business of insurance."). Nevertheless, the HMOs assert that AWP laws are aimed at the administration of their HMO practices instead of at the benefits provided to their insureds. The HMOs then argue that ERISA only saves from preemption laws that concern the latter.

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[5] As this Court has recently recognized, "HMOs have taken over much business formerly performed by traditional indemnity insurers, and they are universally regulated as insurers under state law." *Rush*, 122 S.Ct. at 2163.

That argument rests principally on an artificially imposed distinction between laws regulating *insurers* and laws regulating *insurance practices*. This argument arises from the statement in *Royal Drug*, 440 U.S. at 211, concerning the exemption from federal antitrust laws being limited to the business of insurance, not the business of insurers. Pet. Br. at 15–17. The ERISA savings clause is not so limited.

The argued dichotomy between laws aimed at the insurance benefits versus laws aimed at the insurers' other activities runs afoul of *FMC Corp. v. Holliday*, 498 U.S. 1 (1987). There, the Court reviewed Pennsylvania's anti-subrogation law, a state law affecting plan administration. Citing *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), the Court held that the law related to plans because it interfered with a uniform administrative scheme. *FMC Corp.*, 498 U.S. at 60. The law fell within the insurance saving clause, however, because it "directly controls the terms of insurance contracts by invalidating any subrogation provisions they contain." *Id.* at 60–61. The Court then concluded that the deemer clause exempts self-insured, but not insured, plans from state laws regulating insurance. "An insurance company that insures a plan remains an insurer for purposes of state laws 'purporting to regulate insurance' after application of the deemer clause. The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer." *Id.* at 61. Thus, so long as a state law regulates an insurer, it is excluded from the scope of the deemer clause and, therefore,

falls within the saving clause. The HMOs' reliance on *Royal Drug* for a dichotomy between laws regulating insurance practices and those regulating the insurers' other activities is misplaced.

2. ERISA's Reservation of State Laws that "Regulate Insurance" and the *Royal Drug* McCarran-Ferguson Definition of the "Business of Insurance" Are Not Synonymous.

Royal Drug is not dispositive of the issue in this case. The ERISA saving clause and the antitrust exemption of the McCarran-Ferguson Act are worded differently and serve different purposes. Saving clause analysis concerns a State's ability to regulate insurers, while McCarran-Ferguson concerns a limitation of competition in violation of antitrust laws. Applying the limits from the McCarran-Ferguson antitrust exemption to the ERISA saving clause mistakenly equates the two provisions.

Royal Drug addressed an antitrust claim against Blue Shield and several pharmacists for entering into an agreement that allegedly produced price-fixing of pharmacy drugs and led to a group boycott of those pharmacists who were not parties to the agreement. 440 U.S. at 207. Blue Shield asserted that the second clause[6] of 15 U.S.C. § 1012(b) exempted it from the antitrust laws. 440 U.S. at 210. The

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[6] The second clause provides "unless such Act specifically relates to the business of insurance."

goal of that provision was not to grant the States broad regulatory authority over the field of insurance; it was to protect the insurance business itself by "carv[ing] out only a narrow exemption . . . from the federal antitrust laws." *U.S. Dep't of Treasury v. Fabe*, 508 U.S. 491, 505 (1993).

By contrast, the ERISA saving clause preserves broad authority for the States to regulate the insurance industry free of preemption. *Metropolitan Life*, 471 U.S. at 739. This is more similar to the first clause of § 1012(b). The first clause states "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance." In *Fabe*, the Court distinguished the two clauses because "the first clause commits laws 'enacted ... for the purpose of regulating the business of insurance' to the States, while the second clause exempts only 'the business of insurance' itself from the antitrust laws." 508 U.S. at 504. The *Fabe* Court then noted that the *National Securities* case was the only previous case addressing the first clause. *Id.* at 501 (citing *SEC v. Nat'l Sec., Inc.*, 393 U.S. 453 (1969)). The *Fabe* Court emphasized that, unlike the second clause, even state laws indirectly aimed at regulating the insurance contract, such as laws regulating the insurer directly, fall within the first clause. 508 U.S. at 504. Essentially, state laws that regulate insurance from a common-sense view prevail under the first clause of §1012(b), but only those meeting all three McCarran-Ferguson factors survive under the second clause.

In *Ward*, this Court applied that analysis in the ERISA saving clause context. 526 U.S. at 367–68. First a common-sense analysis of the state law determines whether the saving clause applies. *Id.* Then, the three-factor test used to analyze the second clause of § 1012(b) acts as a relevant guidepost, but is not determinative. *Id.* at 373–74. It is relevant because a law that directly regulates the insured-insurer relationship, i.e., falls within the second clause, must fall within the first clause of § 1012(b). It is not determinative, however, because the ERISA saving clause, like the first clause of § 1012(b), captures *in*direct regulations—laws regulating an insurer's other activities. The HMOs reliance on the *Royal Drug* case incorrectly equates the ERISA saving clause with the second clause of § 1012(b).

Although the pharmacy agreement at issue in *Royal Drug* might be thought of as threatening free competition because it excluded certain providers from providing services to insureds, AWP laws do not. Quite to the contrary, proponents of AWP laws claim that these laws actually increase competition among the providers who have membership on an HMO's provider list. But the merits of that argument are of no consequence here, because the only question is whether Congress intended to preempt the States from enforcing those laws by providing a clause in ERISA that saves laws which "regulate insurance." The state *amici* think congressional intent to preserve the States ability to enforce insurance laws against insurers is based squarely on by the broad language of the ERISA saving clause. The HMOs ask this Court to reverse its prior decisions and hold

otherwise based on an antitrust exemption found in the McCarran-Ferguson Act. That request should be denied.

CONCLUSION

The Court should affirm the judgment of the Sixth Circuit.

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Supreme Court of the United States

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., *et al.*,
Petitioners,

v.

JANIE MILLER, COMMISSIONER OF THE KENTUCKY DEPARTMENT OF INSURANCE,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF OF THE COUNCIL OF STATE GOVERNMENTS, NATIONAL CONFERENCE OF STATE LEGISLATURES, NATIONAL GOVERNORS ASSOCIATION, NATIONAL LEAGUE OF CITIES, U.S. CONFERENCE OF MAYORS, INTERNATIONAL CITY/COUNTY MANAGEMENT ASSOCIATION, AND NATIONAL ASSOCIATION OF COUNTIES AS *AMICI CURIAE* SUPPORTING RESPONDENT

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QUESTION PRESENTED

Whether Kentucky's Any Willing Provider statutes are saved from preemption by ERISA's saving clause because they are state laws that regulate insurance.

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INTEREST OF THE *AMICI CURIAE*

Amici are organizations whose members include state, county, and municipal governments and officials throughout the United States.[1] *Amici* have a compelling interest in preserving the States' longstanding power to regulate insurance and in ensuring that ERISA is read in a manner consistent with that authority.

For 150 years the regulation of insurance has been the responsibility of the States. Congress expressly preserved this exercise of the States' historic police powers in the McCarran-Ferguson Act and reaffirmed it thirty years later in ERISA's saving clause. Any Willing Provider laws such as the Kentucky statutes at issue in this case and those adopted in roughly twenty-five other States are classic instances of state insurance regulation. Their purpose is to redress the imbalance that exists in those HMOs that limit entry into provider networks, thereby unduly restricting provider choice on the part of insured persons.

Petitioners urge this Court to disregard the well-settled legal principles—applied to HMOs just last term in *Rush Prudential HMO, Inc. v. Moran*, 122 S.Ct. 2151 (2002)—that give an appropriately broad reading to the scope of ERISA's saving clause for state laws that regulate insurance. *Amici* respectfully submit that if this Court were to accept petitioners' constricted reading of ERISA's saving clause, state insurance regulation would be severely curtailed and a deleterious regulatory void would result because the Federal Government has consistently looked to the States as the primary regulators of insurance.

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[1] The parties have consented to the filing of *amicus* briefs in this case by filing blanket consents with the Clerk of the Court. This brief was not authored in whole or in part by counsel for a party, and no person or entity, other than *amici* or their members, has made a monetary contribution to the preparation or submission of this brief.

Because the issue presented critically affects the States' ability to exercise core components of their historic police powers, *amici* submit this brief to assist the Court in the resolution of this case

SUMMARY OF ARGUMENT

As this Court has long recognized, the authority to regulate insurance is one of the States' historic police powers. Congress consistently defers to state regulation in this area and expressly authorized state regulation of insurance when it enacted the McCarran-Ferguson Act and, thirty years later, ERISA's saving clause.

ERISA expressly saves from federal preemption "any law of any State which regulates insurance." 29 U.S.C. § 1144(b)(2)(A). In applying the saving clause, the Court uses a two-part test. First, the Court asks whether, as a matter of common sense, the law is "specifically directed toward [the insurance] industry." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987). Second, the Court "test[s] the results of the common-sense enquiry by employing the three factors used to point to insurance laws spared from federal preemption under the McCarran-Ferguson Act." *Rush Prudential HMO, Inc. v. Moran*, 122 S. Ct. 2151, 2159 (2002) (citation omitted).

A. Kentucky's AWP laws regulate insurance as a matter of common sense because they home in on the insurance industry—they are specifically and exclusively targeted at entities engaged in the business of insurance. Furthermore, they affect the nature of the contract between the insurer and the insured by regulating an insurer's ability to limit the size of the provider network made available to the insured. While AWP laws may also affect the relationship between insurers and providers, they are ultimately aimed at increasing an insured's choice of providers.

Moreover, Kentucky's AWP laws are grounded in policy concerns related to the insurer-insured relationship. Indeed, Kentucky's AWP laws were enacted precisely in order to regulate the insurer-insured relationship and "increase benefits to the insureds by giving them greater freedom to choose health care providers under the plans." Pet. App. 30a. Finally, Kentucky's AWP laws regulate insurance as a matter of common sense because they are enforced by Kentucky's insurance commissioner, who is granted authority to revoke an insurer's certificate of operation if the insurer refuses to comply with the AWP provisions. *See* Ky. Rev. Stat. Ann. § 304.3-200 (Michie 1996).

B. The common-sense conclusion that Kentucky's AWP laws regulate insurance is validated by all three of the McCarran-Ferguson factors.

The first factor asks whether a law "targets practices or provisions that 'ha[ve] the effect of transferring or spreading a policyholder's risk.'" *Rush Prudential*, 122 S. Ct at 2163 (citation omitted). Kentucky's AWP statutes satisfy this factor in two ways. First, by requiring insurers to widen provider pools, the statutes reduce the risk that an insured will have to pay higher out-of-pocket costs because a health care provider of choice is not within the HMO's network. Thus, the Kentucky AWP statutes decrease the insureds' risk of paying higher out-of-pocket costs to receive treatment from doctors of their choice, rather than of the HMO's choosing. Second, AWP laws may also reapportion risk insofar as they may require insureds to bear the additional cost of greater provider choice through higher premiums.

The Kentucky AWP statutes also satisfy the second McCarran-Ferguson factor, which asks whether the law affects an integral part of the policy relationship between the insurer and the insured. By requiring open networks, Kentucky's AWP laws make it more likely that insureds will be able to choose their preferred doctors. As noted by the court

below, this "removal of a restriction on availability of providers is . . . a benefit conferred on the insureds. It effectively changes the terms of the policy, admittedly not in terms of covered medical condition but in terms of covered treatment by health care providers." Pet. App. 31a-32a. Moreover, even if insureds' first-choice providers are not in the network, a larger network nonetheless enhances their range of choices. By legislatively amending the terms of insurance contracts to confer greater provider choice on insureds, Kentucky's AWP statutes make this choice an integral part of the policy relationship between insurer and insured.

Petitioners argue that provider choice is no more significant here than in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), where the Court concluded that a limited network of pharmacists was not an integral part of the policy relationship and that policyholders were "basically unconcerned" with pharmacy choice. *Id.* at 214. This observation, made by the Court in the context of a determination of whether an insurer was entitled to an exemption from federal antitrust laws, is not relevant here.

First, the Kentucky AWP laws reflect a state legislative determination that provider choice is important to insureds. In contrast, the policyholders in *Royal Drug*, by accepting the terms of the policy, did not demonstrate a concern about choice. Second, by expanding provider networks, Kentucky's AWP laws make choice an integral part of the policy. Finally, and most importantly, petitioners' *Royal Drug* argument fails to account for the fact that state laws regulating insurance are not evaluated under ERISA's saving clause in the same way as is an insurer's right to an antitrust exemption under the McCarran-Ferguson Act. *See U.S. Dep't of Treasury v. Fabe*, 508 U.S. 491, 504-06 (1993). Thus, preservation of Kentucky's AWP laws from preemption by ERISA is entirely consistent with the outcome

of *Royal Drug*—both ultimately favor regulation of the insurance industry, by the States as a general matter and by the Federal Government as to antitrust.

Kentucky's AWP statutes also satisfy the third McCarran-Ferguson factor—whether the law "targets practices or provisions that '. . . [are] limited to entities within the insurance industry.'" *Rush Prudential*, 122 S. Ct. at 2163 (citation omitted). AWP laws target insurance industry cost-cutting practices that limit alternatives for treatment available to insureds. These laws have no application outside the insurance industry. In this regard, petitioners' argument that the target of Kentucky's AWP laws is the provider-insurer contract ignores the meaning of the third McCarran-Ferguson factor, which asks whether the law *targets* practices or provisions limited to insurance industry entities. While these laws may have *consequences* that affect health care providers, this does not alter the fact that the target of the Kentucky AWP laws is practices of health care insurers and the provider networks they offer to insureds.

C. Reversal of the judgment below could call into question the validity of numerous state laws, as approximately twenty-five States have enacted some form of AWP statute. Preemption under ERISA would also be inconsistent with the presumption that federal statutes should not be construed to create a regulatory void by preempting state regulation in areas where there is no federal regulation. The substantive policy implications of preemption are even more pronounced in the context of insurance law, an area where Congress has consistently deferred to state regulation.

Because ERISA does not regulate either HMOs' insurance practices or their health care practices, a deleterious regulatory void would be the inevitable result of a reversal of the judgment below. Given the manifest importance of state insurance regulation and state regulation of insurers' health care practices, the judgment below should be affirmed.

ARGUMENT

ANY WILLING PROVIDER LAWS ARE STATE LAWS REGULATING INSURANCE THAT ARE SAVED FROM PREEMPTION BY ERISA'S SAVING CLAUSE.

As this Court has long recognized, the regulation of insurance is a historic function of the States. *See, e.g.*, *SEC v. Variable Annuity Life Ins. Co.*, 359 U.S. 65, 68 (1959) ("When the States speak in the field of 'insurance,' they speak with the authority of a long tradition."); *see also Northwestern Nat'l Life Ins. Co. v. Riggs*, 203 U.S. 243, 254 (1906). In enacting the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 *et seq.*, Congress declared as national policy that "the continued regulation and taxation by the several States of the business of insurance is in the public interest." *Id.* § 1011. Section 2(b) of McCarran-Ferguson expressly states that "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance." *Id.* § 1012(b).

This national policy was reaffirmed in ERISA, whose saving clause, 29 U.S.C. § 1144(b)(2)(A), exempts from preemption "any law of any State which regulates insurance." Indeed, ERISA's "saving clause and the McCarran-Ferguson Act serve the same federal policy and utilize similar language to define what is left to the States." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 744 n.21 (1985). As the Court has held, "[t]he ERISA saving clause, with its similarly worded protection of 'any law of any State which regulates insurance,' appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States." *Id.* While ERISA's saving clause, like the McCarran-Ferguson Act, necessarily results in variations in insurance regulation from State to State, "[s]uch

disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation." *Rush Prudential HMO, Inc. v. Moran*, 122 S. Ct. 2151, 2167 (2002) (citing *Metro. Life*, 471 U.S. at 747).

The two-step analysis for determining whether a state law regulates insurance within the meaning of ERISA's saving clause is well established. The Court "start[s] with a 'common-sense view of the matter,' under which 'a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry.'" *Rush Prudential*, 122 S. Ct. at 2159 (quoting *Metro. Life*, 471 U.S. at 740; *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987)). A law which "regulates the terms of . . . insurance contracts" is also "a law 'which regulates insurance'" under the common-sense test. *Metro. Life*, 471 U.S. at 740 (quoting 29 U.S.C. § 1144(b)(2)(A)).

Second, this Court "test[s] the results of the common-sense enquiry by employing the three factors used to point to insurance laws spared from federal preemption under the McCarran-Ferguson Act." *Rush Prudential*, 122 S. Ct. at 2159 (citation omitted). These are: (1) whether the practice in question has the effect of transferring or spreading an insured's risk; (2) whether the law regulates an integral part of the relationship between the insurer and the insured; and (3) whether the law applies only to entities within the insurance industry. *Id.* at 2163 (citing *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)). "Because the factors are guideposts, a state law is not required to satisfy all three McCarran-Ferguson criteria to survive preemption. . . ." *Id.* (citing *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358, 373 (1999)).

Kentucky's AWP laws regulate insurance as a matter of common sense, a conclusion that is validated by all three of the McCarran-Ferguson factors. The judgment of the court of appeals should therefore be affirmed.

A. Kentucky's AWP Laws Regulate Insurance As A Matter Of Common Sense.

In *Rush Prudential*, this Court expressly held that HMOs are "insurers" under ERISA's saving clause.[2] *See* 122 S. Ct. at 2160 ("an HMO . . . provides health care, and it does so as an insurer"). The only question that remains is whether Kentucky's AWP laws regulate HMOs acting as insurers.

1. *Kentucky's AWP Laws Are Specifically Directed At Insurance Industry Entities And Practices.*

Kentucky's AWP laws regulate insurance as a matter of common sense because they are specifically directed at the insurance practices and policies of entities within the insurance industry. This is clear from the plain language of Kentucky's AWP statutes. They define health "insurer" as "any insurance company; *health maintenance organization*; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health services corporation authorized to transact health insurance business in Kentucky." Ky. Rev. Stat. Ann. § 304.17A-005(23) (Michie Supp. 2001) (emphasis added).

Furthermore, Kentucky's AWP laws are targeted exclusively at entities within the insurance industry, another

[2] HMOs are only one form of managed care entity. "The term 'Managed Care Organization' is used more broadly to refer to any number of systems combining health care delivery with financing." *Rush Prudential*, 122 S. Ct. at 2157 n.1 (citation omitted). Indeed, this Court has recognized that "'an observer may be hard pressed to uncover the differences among products that bill themselves as HMOs, [preferred provider organizations], or managed care overlays to health insurance.'" *Id.* at 2161 (citation omitted). Although AWP laws frequently encompass managed care entities other than HMOs, *amici* use the term "HMO" in this brief because that is the term used by petitioners and the court below.

consideration highly germane to the common-sense test. *See Rush Prudential*, 122 S. Ct. at 2164 (holding that state law satisfied the common-sense test in part because it "does not apply to entities outside the insurance industry (although it does not, of course, apply to all entities within it)"). *Accord UNUM*, 526 U.S. at 368 (fact that California's notice-prejudice rule "is directed specifically at the insurance industry and is applicable only to insurance contracts" was significant in this Court's determination that the rule "satis-[fied] the common-sense view as a regulation that homes in on the insurance industry").

Not only do Kentucky's AWP laws apply exclusively to insurance companies, they affect the nature of the insurance being provided through the insurance contract. This further confirms that they regulate insurance as a matter of common sense. *See Metro. Life*, 471 U.S. at 740-41 (fact that state law regulated the substantive terms of insurance contracts established that the law satisfied common-sense test). AWP laws affect the nature of the insurer's promise by regulating the insurer's ability to limit the size of the network of providers available to the insured.[3] *See* Pet. Br. 4 ("The purpose and effect of these AWP laws is to require petitioners and other HMOs to throw open their closed provider networks to any provider in the geographic area willing to abide by the terms of their network contracts."). This "effect of eliminating an insurer's autonomy to guarantee terms congenial to its own

[3] It is ironic that petitioners contend that AWP laws are not integral to the relationship between the insurer and the insured, Pet. Br. 34, given that some HMOs use the size of the network as a selling point to potential customers, claiming "not just that they have a large panel but also that they have your current provider on that panel." *See* Dianne McCarthy, Note, *Narrowing Provider Choice: Any Willing Provider Laws After* New York Blue Cross v. Travelers, 23 Am. J.L. & Med. 97, 109 (1997) (quoting an HMO advertisement claiming: "'I did not choose them because they had 11,000 doctors, I chose them because they had mine'").

interests is the stuff of garden variety insurance regulation through the imposition of standard policy terms." *Rush Prudential*, 122 S. Ct. at 2171 (citing *Metro. Life*, 471 U.S. at 742).

Petitioners contend that Kentucky's AWP laws do not regulate insurance as a matter of common sense because they regulate insurers' contracts with providers, not insureds. Pet. Br. 35-36. This argument is without merit. Although some AWP laws may use the provider-insurer contract as the mechanism of regulation, the ultimate consequence is that insureds are likely to have more provider choices than they would in the absence of regulation. While AWP laws may affect the relationship between insurers and providers, they are laws that fundamentally change the relationship between insurers and insureds. *See Metro. Life*, 471 U.S. at 744 ("'Statutes aimed at protecting or regulating [the insurer-policyholder] relationship, *directly or indirectly*, are laws regulating "the business of insurance."'") (quoting *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969)) (emphasis added).

Moreover, in *Rush Prudential* this Court held that ERISA's saving clause does not require that a state law be hermetically sealed around the insurance aspects of health care "as long as providing insurance fairly accounts for the application of state law." 122 S. Ct. at 2160. Indeed, an effect on the insurer-provider relationship does not make an AWP law any less a law "which regulates insurance," 29 U.S.C. § 1144(b)(2)(A), because "[n]othing in [ERISA's] saving clause requires an either-or choice between health care and insurance in deciding a preemption question." *Rush Prudential*, 122 S. Ct. at 2160.

It is thus unpersuasive to argue that AWP laws are pre-empted because they are health care laws rather than insurance laws. *See* Br. *Am. Cur.* Society for Human Res. Mgmt. 19-21. *Rush Prudential* squarely held that an HMO

"both . . . provides health care and . . . does so as an insurer," and is thus subject to state insurance regulation. 122 S. Ct. at 2160. The inherent health care implications of Kentucky's AWP laws therefore do not warrant a finding of ERISA preemption.

Moreover, even if they are viewed as health care regulations as well as insurance regulations, AWP laws still fall within the ambit of state authority, for "'[i]n the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose.'" *Id.* at 2171 (quoting *Pegram v. Herdrich*, 530 U.S. 211, 236 (2000)). In this regard, "it helps to go back to where we started and recall the ways States regulate insurance in looking out for the welfare of their citizens." *Id.* at 2170. States with AWP laws "ha[ve] chosen to regulate insurance as one way to regulate the practice of medicine [which this Court has] previously held to be permissible under ERISA." *Id.* at 2170-71 (citing *Metro. Life*, 471 U.S. at 741). Furthermore, this Court has noted that state insurance regulation that is tied to the practice of medicine "is probably inseparable from enforcing the quintessentially state-law standards of reasonable medical care," *id.* at 2171, which supports the conclusion that ERISA's saving clause applies.

2. *Kentucky's AWP Laws Are Enforced By The State Insurance Department.*

The fact that Kentucky's Department of Insurance enforces the State's AWP laws, *see* Ky. Rev. Stat. Ann. § 304.3-200 (Michie 1996), as do insurance departments in many other States,[4] confirms the conclusion that AWP laws regulate

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[4] *See, e.g.*, Ala. Code § 27-45-7 (Supp. 2002) ("The commissioner of insurance shall not approve for sale in this state any health insurance policy . . . providing for pharmaceutical services, including without limitation, prescription drugs, which does not conform to the provisions of this article. . . ."); Ga. Code Ann. § 33-20-26 (2000) ("The Commissioner

insurance. "'The relationship between the insurer and insured, . . . its interpretation, *and enforcement*—these were the core of the "business of insurance."'" *Metro. Life*, 471 U.S. at 744 (quoting *SEC v. National Securities*, 393 U.S. at 460) (emphasis added); *see also Rush Prudential*, 122 S. Ct. at 2161 n.5 (state classification of a statute as an insurance law is "relevant to the enquiry" of whether the statute regulates insurance).

Contrary to the contention that Kentucky's AWP laws were placed in the insurance code merely as a ruse to evade ERISA preemption, *see* Br. *Am. Cur.* Community Health Partners 12-13, Kentucky's legislature granted the state insurance commissioner power to revoke an insurer's certificate of authority if an insurer refuses to comply with the AWP provisions. *See* Ky. Rev. Stat. Ann. § 304.3-200(1)(c) (Michie 1996) ("The commissioner may . . . revoke an insurer's certificate of authority if he finds . . . that the insurer has . . . [w]illfully violated any provision of this code. . . .").

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shall have the authority to take appropriate actions authorized by this title for the protection of a health care corporation's subscribers and the public health and welfare. . . ."); Mass. Gen. Laws Ann. ch. 176D, § 3B (West 1998) ("The commissioner of the division of insurance shall have authority to enforce the provisions of this section."); Miss. Code Ann. § 83-9-6(7) (1999) ("The Commissioner of Insurance shall not approve any health benefit plan providing pharmaceutical services which does not conform to this section."); N.C. Gen. Stat. § 58-51-37(i) (2^01) ("The Commissioner shall not approve any health benefit plan providing pharmaceutical services which does not conform to this section."); N.D. Cent. Code § 26.1-36-12.2(5) (1995) ("The commissioner of insurance shall enforce the provisions of this section."); Utah Code Ann. § 31A-22-617(4)(b) (2001) ("The commissioner in consultation with the executive director of the Department of Health may designate qualified persons to perform an audit of the quality assurance program."); Wash. Rev. Code § 48.44.020(2)(f) (1999) ("The commissioner may on examination . . . disapprove any contract form . . . [i]f it violates any provision of this chapter[.]").

This revocation authority is identical to that available to the Commissioner to enforce the other provisions of the Kentucky Insurance Code. *See id.*

3. *Kentucky's AWP Laws Are Grounded In Policy Concerns Specific To The Insurance Industry.*

Finally, Kentucky's AWP laws are "grounded in policy concerns specific to the insurance industry," a consideration that was "key to [this Court's] decision" in *UNUM*. *See* 526 U.S. at 372. Kentucky's AWP laws were enacted to regulate the relationship between insurers and insureds by requiring HMOs to open their networks to additional providers, thereby "increas[ing] benefits to the insureds by giving them greater freedom to choose health care providers under the plans."[5] Pet. App. 30a; *see also, e.g.*, Ark. Code. Ann. § 23-99-202 (Michie 1999) (General Assembly finds that "patients should be given the opportunity to see the health care provider of their choice. In order to assure the citizens of the State of Arkansas the right to choose the provider of their choice, it is the intent of the General Assembly to provide the opportunity of providers to participate in health benefit plans."). Indeed, the Kentucky legislature enacted its original AWP statutes as

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[5] Other States have expressed similar legislative purposes when enacting AWP statutes. For example, the Idaho General Assembly enacted an AWP law as part of the State's "Managed Care Reform Act," Idaho Code § 41-3901 *et seq.* (Michie 1998 & Supp. 2002). In providing insureds with broad access to all willing providers, the Idaho legislature declared that it "wishe[d] to eliminate legal barriers to the establishment of managed care plans which provide readily available, accessible and quality health care to their members." *Id.* at § 41-3902. Similar legislative findings have been made in support of pharmacy AWP laws. *See, e.g.*, Del. Code. Ann. tit. 18, § 7302(a) (1999) ("pharmaceutical services and prescription drugs are an essential service to the people of this State and . . . the broadest possible access to such services should be mandated").

part of a major health insurance reform measure. *See* Julia Field Costich & Mike Helton, *The Kentucky Health Reform Act*, 22 N. Ky. L. Rev. 381, 391 (1995).

From the foregoing it is clear as a matter of common sense that Kentucky's AWP laws regulate insurance under ERISA's saving clause.

B. Consideration Of The McCarran-Ferguson Factors Reinforces The Conclusion That Kentucky's AWP Laws Regulate Insurance.

The common-sense conclusion that Kentucky's AWP laws are not preempted by ERISA is confirmed by "the three factors used to point to insurance laws spared from federal preemption under the McCarran-Ferguson Act." *Rush Prudential*, 122 S. Ct. at 2159. Moreover, while "a state law is not required to satisfy all three McCarran-Ferguson criteria to survive preemption," *id.* at 2163 (citing *UNUM*, 526 U.S. at 373), Kentucky's AWP laws satisfy all three.[6]

1. *This Court Reads The McCarran-Ferguson Factors Broadly To Protect The States' Paramount Role In Regulating Insurance.*

At the outset, *amici* note that petitioners, in addressing the McCarran-Ferguson factors, fail to recognize that the Court applies them in two distinct contexts. The McCarran-Ferguson factors were first identified in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). *See Pireno*, 458 U.S. at 126-30 (citing and quoting *Royal Drug*, 440 U.S. at 209-31). *Royal Drug* involved the application of the second clause of § 2(b) of the McCarran-Ferguson Act, 15

[6] This Court has variously described the McCarran-Ferguson factors as "guideposts," *Rush Prudential*, 122 S. Ct. at 2163, "considerations," *UNUM*, 526 U.S. at 373 (quoting *Pilot Life*, 481 U.S. at 49), and "criteria," *id.* (quoting *Pireno*, 458 U.S. at 129). This further indicates their flexible role in saving clause analysis.

U.S.C. § 1012(b), which creates an *exemption* from the federal antitrust laws for the "business of insurance." *See* 440 U.S. at 210. The *Royal Drug* Court emphasized "that exemptions from the antitrust laws are to be narrowly construed." *Id.* at 231; *accord Pireno*, 458 U.S. at 126 ("our precedents consistently hold that exemptions from the anti-trust laws must be construed narrowly") (citing *FMC v. Seatrain Lines, Inc.*, 411 U.S. 726, 733 (1973)). The Court accordingly developed a criteria-based analysis consistent with fulfilling the Act's "*secondary* purpose of . . . giv[ing] insurance companies only a limited exemption from the antitrust laws." *Royal Drug*, 440 U.S. at 218 n.18.

Analysis under the second clause of § 2(b), the antitrust exemption, is not pertinent here. Rather, the first clause of § 2(b) of McCarran-Ferguson, which implements Congress' "*primary* purpose of . . . preserv[ing] state regulation of the activities of insurance companies," *id.*, is controlling. This saving clause is given a far broader reading than the antitrust exemption in the second clause. *See U.S. Dep't of Treasury v. Fabe*, 508 U.S. 491, 504-06 (1993); *see also id.* at 501 ("'Statutes aimed at protecting or regulating this relationship [between insurer and insured], *directly or indirectly*, are laws regulating the 'business of insurance,' within the meaning of the phrase.") (emphasis added) (quoting *SEC v. National Securities*, 393 U.S. at 460).

This Court has noted that "[t]he ERISA saving clause, with its similarly worded protection of 'any law of any State which regulates insurance,' appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States" in the first clause of § 1012(b). *Metro. Life*, 471 U.S. at 744 n.21. ERISA's saving provision, like the first clause of § 2(b) of McCarran-Ferguson, saves from preemption "any law of any State which regulates insurance." 29 U.S.C. § 1144(b)(2)(A). ERISA's saving clause is thus at least as protective of state insurance laws as the first clause of § 2(b) of McCarran-

Ferguson. Indeed, the statutes have a common goal: to preserve "the States[']broad regulatory authority over the business of insurance." *Fabe*, 508 U.S. at 505; *see also Metro. Life*, 471 U.S. at 744 n.21. This conclusion follows from the textual similarity of ERISA's saving clause to the first clause of § 2(b) of the McCarran-Ferguson Act,[7] the identical purpose of the two provisions, and from this Court's use of the McCarran-Ferguson factors to "test the results of the common-sense enquiry" that is the first step in ERISA saving clause analysis. *Rush Prudential*, 122 S. Ct. at 2159.

Moreover, the Court has "indicated that the McCarran-Ferguson factors are considerations [to be] weighed in determining whether a state law regulates insurance, and that none of these criteria is necessarily determinative in itself." *UNUM*, 526 U.S. at 373 (internal citations and quotation marks omitted); *see also Rush Prudential*, 122 S. Ct. at 2163 ("Because the factors are guideposts, a state law is not required to satisfy all three McCarran-Ferguson criteria to survive preemption. . . .") (citation omitted). This flexible approach is informed by the fact that when the McCarran-Ferguson criteria are applied in ERISA saving clause analysis the interest of the State in regulating the insurance industry must also be taken into account. For this reason, these factors are read more flexibly where these saving provisions are at

[7] *Compare* 29 U.S.C. § 1144(b)(2)(A) (saving from preemption "any law of any State which regulates insurance") *and* 15 U.S.C. § 1012(b) cl. 1 (saving "any law enacted by any State for the purpose of regulating the business of insurance") *with* 15 U.S.C. § 1012(b) cl. 2 (providing that federal antitrust laws "shall be applicable to the business of insurance to the extent that such business is not regulated by State law"). Thus both this Court's holding in *Metropolitan Life* and the text of these statutes directly contradict petitioners' suggestion that ERISA's clause saving state laws that regulate insurance has a "close linguistic similarity" to McCarran-Ferguson's business of insurance antitrust exemption. *See* Pet. Br. 37.

issue and thus are also read more broadly than McCarran-Ferguson's antitrust immunity. *See Fabe*, 508 U.S. at 504 (holding the first clause of § 2(b) is not so "narrowly circumscribed" as is analysis under the second clause); *see also Rush Prudential*, 122 S. Ct. at 2163; *UNUM*, 526 U.S. at 373. Consequently, Kentucky's AWP laws need not satisfy all three factors in order for the result of the common-sense test to be confirmed. *Rush Prudential*, 122 S. Ct. at 2163; *UNUM*, 526 U.S. at 373. In fact, Kentucky's laws satisfy all three factors.

2. *Kentucky's AWP Laws Satisfy All Three McCarran-Ferguson Factors.*

The first McCarran-Ferguson factor asks whether the law at issue "targets practices or provisions that 'ha[ve] the effect of transferring or spreading a policyholder's risk.'" *Rush Prudential*, 122 S.Ct at 2163 (quoting *Pireno*, 458 U.S. at 129). AWP laws satisfy this factor in two respects. First, AWP statutes transfer some of the risk that an insured will have to pay higher out-of-pocket costs to use a health care provider of choice because the insured is not satisfied with the choices from the network. For example, under petitioners' HMO policy, an insured scheduling office visits with a physician outside of the HMO's provider network must pay a medical services copayment of $150 plus twenty percent of the total cost incurred per office visit. *See* J.A. 86a-88a. By contrast, if the insured visits a doctor within the provider network, he or she pays only a $10 co-payment per visit. *See id.* at 88a. By broadening the number of doctors in a provider network, AWP laws make it more likely that insureds will

pay only the standard co-payment for their office visits because they will able to select their preferred provider from within the network.[8]

Second, AWP laws may require policyholders or insureds to bear additional costs resulting from greater provider choice insofar as HMOs charge higher premiums or reduce coverage in response to AWP laws.[9] AWP laws also have the effect of spreading risk among policyholders as compared to policies that require only those insureds who go outside the network to bear a higher cost for doing so. *See Stuart Circle Hosp. Corp. v. Aetna Health Mgmt.*, 995 F.2d 500, 503 (4th Cir.) (by prohibiting "unreasonable restrictions [on] providers," AWP laws "spread[] the cost component of the policyholder's risk among all the insureds, instead of requiring the policyholder to shoulder all or part of this cost when seeking care or treatment from an excluded doctor or hospital of his or her choice"), *cert. denied*, 510 U.S. 1003-04 (1993). *Cf. Metro. Life*, 471 U.S. at 743 (holding that mandated-benefit law effectively forcing good-risk policyholders to bear part of the cost of mental-health insurance by becoming part of the risk pool "obviously regulates the spreading of risk"). Thus,

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[8] As the court below explained, while there is no guarantee that an insured's preferred provider will join a network,

> it does not...change the fact that the statutes open an otherwise closed door, insofar as the availability of health care providers is concerned. Some may choose to go through that door and join the group of providers while others may not, but this does not mean that removal of a restriction on availability of providers is not a benefit conferred on the insureds.

Pet. App. 31a.

[9] Petitioners argue that AWP laws necessarily "increase the cost of managed care." Pet. Br. 5 n.4. To the extent such cost increases occur, one possible response of insurers may be to pass them on directly in the form of higher premiums. *See* Note, *Health Care Law—HMO Regulation—Arkansas Requires HMOs to Accept Any Provider Willing to Join Their Networks*, 109 Harv. L. Rev. 2122, 2125 (1996).

AWP laws satisfy the first McCarran-Ferguson factor by spreading risk both vertically (between insurers and policyholders) and horizontally (among policyholders).

The relationship of AWP laws to risk is also apparent from the fact that HMOs were a low-cost response to traditional indemnification insurance in which insureds had freedom to choose providers. *Cf. Pegram*, 530 U.S. at 218 ("In a fee-for-service system, a physician's financial incentive is to provide more care, not less, so long as payment is forthcoming."). HMOs were purposefully designed to restrict choice and thereby save money, both for insurers and insureds, the latter through lower premiums. *Cf. id.* at 219 (HMOs implement numerous "cost-controlling measures [that] are commonly complemented by specific financial incentives to physicians, rewarding them for decreasing utilization of health-care services, and penalizing them for what may be found to be excessive treatment") (citations omitted). AWP laws, in turn, were a state regulatory response designed in part to provide insureds with more choices than HMOs would otherwise allow under their existing policies. *See* James W. Childs, Jr., Comment, *You May Be Willing, But Are You Able?: A Critical Analysis of "Any Willing Provider" Legislation*, 27 Cumb. L. Rev. 199, 217 (1996) (explaining that "public support for AWP legislation may more realistically represent the balance of cost and choice that the 'public' is seeking"). Thus, by restoring a measure of the choice provided by traditional fee-for-service insurance, AWP laws reallocate risk between insurer and insured.

Petitioners assert that AWP laws cannot satisfy the risk-spreading factor because "the 'risk' HMOs insure against is not the loss arising out of a desire to pay one provider rather than another for particular care, . . . [but] is the loss arising

from the need to pay for care at all."[10] Pet. Br. 23-24. The flaw in this position is that the risk of paying for the care required when an insurable event occurs varies with what the insurer agrees to underwrite as compensable treatment for the event. *See, e.g.*, *Stuart Circle*, 995 F.2d at 503 (noting that "[t]here are several components to the 'policyholder's risk'" and explaining how AWP laws relate to those components). In short, where an insurance contract limits the insured's choice of health care providers, AWP laws legislatively amend the terms of the insurance agreement between the insurer and insured, redistributing the original risk allocation by providing the insured with a broader range of provider choice. By changing the terms of the contract and redistributing risk, AWP laws satisfy the McCarran-Ferguson "risk-spreading" factor.

The second McCarran-Ferguson factor asks whether a law "targets practices or provisions . . . '[that are] an integral part of the policy relationship between the insurer and the insured.'" *Rush Prudential*, 122 S. Ct at 2163 (quoting *Pireno*, 458 U.S. at 129). This factor is easily satisfied by AWP laws. This conclusion holds true both for laws that require insurers to open their networks to a broad range of

[10] Petitioners also argue that the risk-spreading factor is not satisfied because "[t]here can be no genuine dispute that HMO provider contracts do not spread or underwrite risk." Pet. Br. 32. This argument focuses on the wrong contractual relationship. When applying the first McCarran-Ferguson factor, this Court focuses on whether the law at issue targets practices or provisions "transferring or spreading a *policyholder's* risk." *Rush Prudential*, 122 S. Ct. at 2163 (emphasis added) (quoting *Pireno*, 458 U.S. at 129). As discussed in greater detail below, *see* p. 25 *infra*, while AWP laws may *affect* the contract between an insurance company and doctors in its provider network, AWP laws principally target the contract between an insurer and the insured.

health care providers, as well as for those state laws applicable only to a limited group of providers, such as pharmacists.[11]

When, like the Kentucky statutes, AWP laws apply to all health care providers, it is apparent, as noted by the majority below, that "[t]he ability of an insured to select a physician of his or her choice to treat a medical condition covered by the insurance is an integral part of the policy relationship between the insurer and the insured." Pet. App. 35a. Petitioners argue that requiring open networks will make it only "marginally" more likely that a policyholder will be able to choose their preferred doctor. Pet. Br. 34. Not only is that assertion open to question, but as the court below noted, whatever its validity it "does not mean that removal of a restriction on availability of providers is not a benefit conferred on the insureds. It effectively changes the terms of the policy, admittedly not in terms of covered medical condition but in terms of covered treatment by health care providers." Pet. App. 31a-32a. Thus, an AWP provision provides insureds with larger provider networks that provide both enhanced choice and a greater likelihood that the insured's preferred provider will be in the network.

AWP laws also provide other important benefits to insureds. As a practical matter, larger networks make it more likely that an insured will know a relative, friend, or coworker who can recommend someone who is in the network. *See* Dianne McCarthy, Note, *Narrowing Provider Choice: Any Willing Provider Laws After* New York Blue Cross v. Travelers, 23 Am. J.L. & Med. 97, 109 (1997) (noting that individuals looking for network providers are more likely to rely on the advice of friends and coworkers rather than "choosing a name from a book or relying on a faceless MCO screener for a referral"). Similarly, if insureds do not like the

[11] As noted *infra* at pp. 27-28, the scope of coverage of AWP laws varies from state to state.

first health care provider that they choose, larger networks will make it easier for them to switch to another doctor. In short, even if insureds are ultimately unable to select their first-choice provider from within the network, a larger network does enhance their range of choice.

Petitioners assert that an enhancement of provider choice is not "'integral'—or even germane—to the *contract of insurance* between insurer and insured." Pet. Br. 34. They argue that because the Court in *Royal Drug* found that insureds were "'basically unconcerned'" with the pharmacy choice that resulted from an arrangement made by an insurer to control the cost of prescription drugs by creating a closed network, an insured's interest in the expansion of physician choice is not "integral" to the contractual relationship between the insurer and the insured. Pet. Br. 35 (quoting 440 U.S. at 214).

The flaw in the petitioners' argument is that *Royal Drug*, which involved McCarran-Ferguson's narrow antitrust immunity, is of limited relevance when a State is regulating insurance. *See Fabe*, 508 U.S. at 504-05. And even if insureds remain "basically unconcerned with arrangements made between [insurers] and participating pharmacies," *Royal Drug*, 440 U.S. at 214—a proposition open to serious question in 2002[12]—petitioners' argument is utterly unpersuasive when

[12] In the twenty-three years since *Royal Drug* was decided, changes in the pharmacy industry have led to instances of extreme customer dissatisfaction with some dominant pharmacy chains, making choice of pharmacy a matter of considerable "concern" to insureds. *See, e.g.*, Sarah Godfrey, *Crummy Variety Store: With 50 Outlets in the District, CVS has a near monopoly on drugs, cough syrup, hair spray—and customer dissatisfaction*, Washington City Paper, March 1-7, 2002 (describing customer dissatisfaction with dominant pharmacy chain in Washington, D.C.), *available at* http://www.washingtoncitypaper.com/archives/cover/2002/print_cover0301.html.

In addition to overall dissatisfaction, privacy concerns may cause a consumer to patronize one pharmacy over another. *See, e.g.*, Rea Blakey, *Pharmacies Jeopardizing Patient Privacy* (June 12, 2002) (discussing business practice of pharmacies selling private medical information to pharmaceutical companies and noting that "[p]atients who don't agree with their providers' practice . . . can try finding a new provider, or pay out of pocket"), *at* http://www.cnn.com/2002/HEALTH/06/12/pharmaceutical.privacy/index.html. Similarly, a desire to avoid drug complications may cause an insured to seek out certain pharmacies.

applied to the expanded physician choice effectuated by Kentucky's AWP law. *See* Br. *Am. Cur.* U.S. on Pet. 15 (policyholders "are likely to be very concerned with the range of providers available to them under [their health insurance] plan").

This Court has made clear that AWP laws require the insurer to alter the terms of the policy in a manner that is an integral part of the policy relationship, as a comparison of two of the Court's cases shows. In *Pireno*, the Court held that an insurer's unilateral use of a peer review committee to advise the insurer as to whether certain medical services were reasonable and necessary was not an integral part of the insurance relationship in part because "[t]he insurer's contract for advice from a third party was no concern of the insured, who was not bound by the peer review committee's recommendation any more, for that matter, than the insurer was." *Rush Prudential*, 122 S. Ct. at 2164 (citing *Pireno*, 458 U.S. at 132). In contrast, in *Rush Prudential* the Court held a state law that added an extra layer of review for an HMO's denial of coverage was integral to the insurer-insured relationship because the law provided "a legal right to the insured [that was] enforceable against the HMO." *Id.* Thus, while a unilaterally created review panel whose decisions are not binding "is a matter of indifference to the policyholder," *Pireno*, 458 U.S. at 132, the same cannot be said for state laws, such as Kentucky's AWP laws, that alter the terms of an HMO's insurance policy and vest legal rights in the

insured; such laws create a right that is integral to the policy relationship and is enforceable by the State's Insurance Commissioner.[13]

The Court's holding in *Royal Drug* is entirely consistent with this analysis. *Royal Drug* held that when an insured buys a policy that gives the insurer a contractual right to specify network pharmacies, the insured has no contractual right to select a different pharmacy. But *Royal Drug* is readily distinguishable from this case, in which the State has created a right to select a provider (or, alternatively, expands the network beyond the insurers' discretion). In this situation, the state-created right becomes an integral part of the insurance relationship. While for antitrust purposes the manner in which the insurer contracts with third parties to provide drug benefits may not be a part of the policy relationship, *see Royal Drug*, 440 U.S. at 216, when a state legislature passes legislation that requires the insurer to admit any willing provider to its pharmacy network, the State has clearly effectuated a change in coverage that is an integral part of the policy relationship.

The fatal flaw in petitioners' *Royal Drug* argument is that there is a fundamental difference between an insurance company entering into contracts that may raise antitrust concerns and seeking an exemption under the second clause of McCarran-Ferguson § 2(b), and a state insurance regulation that is saved from preemption by the first clause of § 2(b). *See Fabe*, 508 U.S. at 504. Thus preservation of Kentucky's AWP laws from preemption by ERISA is entirely consistent with the outcome of *Royal Drug* – both ultimately favor regulation of the insurance industry, by the States as a general matter and by the Federal Government as to antitrust. To conclude otherwise would lead to the anomalous result that

[13] *See* discussion *supra* at pp. 11-13 & n. 4 concerning state enforcement of AWP laws by insurance commissioners in Kentucky and other States.

the McCarran-Ferguson factors *exempt* the insurance industry from state regulation when "[t]here is no question that the *primary* purpose of the McCarran-Ferguson Act was to preserve state regulation of the activities of insurance companies." *Royal Drug*, 440 U.S. at 218 n.18.

Finally, for the same reasons that AWP laws regulate insurance as a matter of common sense, *see* pp. 8-14 *supra*, AWP statutes satisfy the third McCarran-Ferguson factor – whether the law "targets practices or provisions that . . . '[are] limited to entities within the insurance industry.'" *Rush Prudential*, 122 S. Ct at 2163 (quoting *Pireno*, 458 U.S. at 129); *see also UNUM*, 526 U.S. at 375.

Petitioners contend that this factor is not satisfied because AWP "laws regulate insurers *and providers*[] by barring the latter from entering into limited network contracts with the former." Pet. Br. 27. This argument ignores the plain meaning of the third McCarran-Ferguson factor, which is whether the law "*targets* practices or provisions . . . [that are] limited to entities within the insurance industry" *Rush Prudential*, 122 S. Ct. at 2163 (quoting *Pireno*, 458 U.S. at 129) (emphasis added); it does not require a hermetic seal that would prevent the law from having an incidental effect on anyone else. AWP laws are obviously targeted at insurance industry practices and the provisions of health insurance policies. While these laws may have *consequences* that affect third-party providers, they are not *targeted* at those providers. *Cf. Fabe*, 508 U.S. at 501 (noting in the context of McCarran-Ferguson's saving clause that laws "'aimed at protecting or regulating this relationship [between insurer and insured], directly or indirectly, are laws regulating the "business of insurance"' within the meaning of the phrase"). (quoting *SEC v. National Securities*, 393 U.S. at 460). Therefore, like the first two McCarran-Ferguson factors, the third factor is also satisfied by Kentucky's AWP laws.

C. ERISA Preemption of Kentucky's AWP Laws Would Deprive States Of The Ability To Regulate HMO Insurance Practices And Would Create A Regulatory Void.

The substantive policy implications of the various AWP laws enacted nationwide militate strongly against a finding of ERISA preemption of Kentucky's AWP laws. Reversal of the judgment below would create a regulatory void in areas where Congress has consistently deferred to state regulation. Petitioners' analysis of the preemptive effect of ERISA would be inconsistent with the presumption that in the absence of federal regulation, federal statutes should not be construed to create a regulatory void by preempting state regulation. *See Pacific Gas & Elec. Co. v. State Energy Res. Conserv. & Dev. Comm'n*, 461 U.S. 190, 207-08 (1983) (finding that States must have regulatory authority over the economic aspects of nuclear power where Congress had not expressly given such authority to the federal government because "[i]t is almost inconceivable that Congress would have left a regulatory vacuum"). For this and other reasons, the Court has instructed that the scope of ERISA preemption must be determined against the background "'assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.'" *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995) (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)).

That point is emphasized by the implications of preemption of AWP laws. Kentucky's AWP laws reflect the public policy concerns that have been raised in numerous state legislatures as a reaction to HMOs' use of limited-provider networks as a means of controlling costs.[14] Indeed, "HMOs

[14] Indeed, petitioners and their *amici* contend that AWP laws are too costly to be justified. Pet. Br. 4-5. This is an argument that has no logical place in this Court's determination as to whether ERISA's saving clause applies. Cost considerations are matter properly considered by the States and by Congress, which remains free to intercede in this area of public policy if it deems intervention appropriate.

became popular because fee-for-service physicians were thought to be providing unnecessary or useless services; today, many doctors and other observers argue that HMOs often ignore the individual needs of a patient in order to improve the HMOs' bottom lines." *Pegram*, 530 U.S. at 220.

Kentucky's AWP laws are what this Court in a related context has called "only one variety of a matrix" of state insurance statutes "that regulate the substantive content of health-insurance policies to further state health policy." *Metro. Life*, 471 U.S. at 729. Indeed, the States continue to develop and experiment with AWP provisions, as "approximately twenty-five States have enacted some form of AWP law." Br. *Am. Cur.* U.S. on Pet. 19. Several AWP laws follow Kentucky's model and prohibit an insurer from discriminating against any health care provider willing to abide by the insurer's terms.[15] Other States' AWP laws require insurers to admit pharmacists or pharmacies willing to meet an insurer's conditions.[16] Other States have likewise

[15] *See, e.g.*, Ark. Code Ann. § 23-99-204(a)(3) (Michie 1999); Ga. Code Ann. § 33-20-16 (2000); Idaho Code § 41-3927(1) (Michie 1998); 215 Ill. Comp. Stat. 5/370h (2000); Ind. Code Ann. § 27-8-11-3(c) (Michie 1999); Wyo. Stat. Ann. § 26-22-503 (Michie 2001).

[16] *See, e.g.*, Ala. Code § 27-45-3 (Supp. 2002); Conn. Gen. Stat. Ann. § 38a-471(f) (2000); Del Code Ann. tit. 18, § 7303 (1999); 215 Ill. Comp. Stat. 134/72(a) (2000); La. Rev. Stat. Ann. § 22:1214(15)(a) (West 1995); Mass. Gen. Laws Ann. ch. 176D, § 3B (West 1998); Miss. Code Ann. § 83-9-6 (1999); N.H. Rev. Stat. Ann. § 420-B:12(V.) (1998); N.J. Stat. Ann. § 26:2J-4.7 (West 1996); N.C. Gen. Stat. § 58-51-37 (2001); N.D. Cent. Code § 26.1-36-12.2 (1995); S.C. Code Ann. § 38-71-147 (Law. Co-op. 2002); S.D. Codified Laws § 58-18-37 (Michie 2000); Tenn. Code Ann. § 56-7-2359 (2000); Tex. Ins. Code Ann. § 21.52B (Vernon Supp. 2002).

elected to apply AWP laws solely to certain types of health care providers. *See, e.g.*, Miss. Code Ann. § 83-41-203 (1999) (optometrists); Okla. Stat. tit. 36, § 3634 (1999) (podiatrists, psychologists, and clinical social workers). Thus, a wide variety of state AWP laws applicable to HMOs could be called into question if the judgment below is reversed.

Moreover, ERISA does not substantively regulate HMOs' medical-treatment decisions. *See, e.g.*, *Travelers*, 514 U.S. at 651 (ERISA "does not go about protecting plan participants and their beneficiaries by requiring employers to provide any given set of minimum benefits"); *Metro. Life*, 471 U.S. at 732 ("ERISA . . . contains almost no federal regulation of the terms of benefit plans."). Accordingly, if state insurance regulation is preempted, HMOs will not be subject to any corresponding federal regulation. ERISA plan participants and their beneficiaries, whom Congress sought to protect by enacting ERISA and its saving clause preserving state insurance regulation, will be deprived of protection unless the States' ability to regulate HMOs remains intact.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted,

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No. 00-1471

OCT 31

IN THE

Supreme Court of the United States

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., *et al.*,

Petitioners,

v.

JANIE MILLER, COMMISSIONER OF THE KENTUCKY DEPARTMENT OF INSURANCE,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF OF *AMICI CURIAE* AMERICAN MEDICAL ASSOCIATION, AMERICAN PSYCHIATRIC ASSOCIATION, NATIONAL MEDICAL ASSOCIATION, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AND KENTUCKY MEDICAL ASSOCIATION IN SUPPORT OF RESPONDENT

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QUESTION PRESENTED

Whether this Court should modify its analysis for determining whether state laws "relate to" employee benefit plans under ERISA's preemption provision, 29 U.S.C. § 1144(a).

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INTEREST OF *AMICI CURIAE*

The American Medical Association ("AMA"), American Psychiatric Association ("APA"), National Medical Association ("NMA"), American College of Obstetricians and Gynecologists ("ACOG"), and Kentucky Medical Association ("KMA") submit this brief as *amici curiae* in support of Respondent Janie Miller, Commissioner of the Kentucky Department of Insurance.[1]

The AMA, an Illinois not-for-profit corporation founded in 1847, is the country's largest medical society. Its approximately 260,000 member physicians practice in all fields of medical specialization in every state. The AMA is dedicated to promoting the science and art of medicine and the betterment of public health.

The APA, with approximately 42,000 members, is the country's leading organization of physicians specializing in psychiatry. The APA and its members have a strong interest in ensuring that the practices of health maintenance organizations ("HMOs") not impair patients' ability to receive, and doctors' ability to deliver, proper medical care.

The NMA is the largest and oldest national organization representing African American physicians and health professionals in the United States. Established in 1895, the

1. Pursuant to Rule 37.6, *amici* state that no counsel for a party authored this brief in whole or in part. *Amicus* AMA joins this brief on its own behalf and as a representative of the Litigation Center of the AMA and the State Medical Societies ("Litigation Center"), a coalition of the AMA and private, voluntary, non-profit state medical societies established to present the views of organized medicine in the courts. The Litigation Center made a monetary contribution to the preparation and submission of this brief. Pursuant to Rule 37.3, the parties have consented to the filing of this brief. The parties' letters of consent have been lodged with the Clerk of this Court.

NMA represents more than 25,000 African American physicians and the patients they serve. The NMA is committed to improving the health status and outcomes of minority and disadvantaged people through its membership, professional development, community health education, advocacy, research, and efforts with federal and private agencies and corporations.

The ACOG, with over 43,000 members, is the nation's leading group of professionals providing health care for women. Founded in 1951, the ACOG works in primarily four areas: (1) serving as a strong advocate for quality health care for women; (2) maintaining the highest standards of clinical practice and continuing education for its members; (3) promoting patient education and involvement in medical care; and (4) increasing awareness among its members and the public of the changing issues facing women's health care.

The KMA is an association of almost 7,000 physicians who reside or practice in the State of Kentucky. It was founded in 1851 to promote the science and art of medicine, protect public health, elevate the standards of medical education, and unite the medical profession in Kentucky.

Amici each seek to protect the integrity of the patient-physician relationship in order to provide quality medical care for patients. *Amici* are interested in this matter because approximately forty states have some type of "any willing provider" ("AWP") statute.[2] These statutes regulate the

2. *See, e.g.*, Ala. Code § 27-45-3 (2002) (choice of pharmacy); Ark. Code Ann. § 23-79-114 (2002) ("no person entitled to benefits . . . shall be denied his or her freedom of choice of any practitioner . . . by any insurer."); Colo. Rev. Stat. § 10-16-107 ("any willing provider"); Ga. Code Ann. § 33-21-29 (2002) (enrollee allowed to name one or more out-of-network providers); Ind. Code Ann.

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relationship between these professionals and managed care organizations ("MCOs"). In addition, the Court's preemption analysis may impact other state laws that govern the relationship between MCOs and physicians.[3]

States have traditionally regulated both the clinical and the economic aspects of the provision of health care, which are often "inextricably mixed." *Pegram v. Herdrich*, 530 U.S. 211, 229 (2000). The Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA"), on the other hand, does not regulate health care, including the practice of medicine. As a result, a regulatory void is created to any extent that ERISA is held to preempt state regulation in this area. Where and how to draw the line between areas of traditional state regulation, like health care, and the

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§ 27-8-11-3 (no hospital, physician, pharmacist willing to meet terms and conditions will be denied right to enter into agreement); Minn. Stat. § 62Q.095 (2001) (expanded network for plans with fewer than 50,000 enrollees shall accept providers that meet credentialing standards, agree to terms of plan's contract, and to comply with protocols); R.I. Gen. Laws § 5-35-21.1 (2001) ("[f]reedom of choice for eye care"); S.D. Codified Laws § 34-1-20 (Michie 2002) (enrollees in HMOs through public health programs have right to choose own physician); Utah Code Ann. § 31A-22-617 (2002) (any licensed provider willing and able to meet terms and conditions of PPO can be designated preferred provider); Wyo. Stat. Ann. § 26-22-503 (Michie 2002) (". . . nor shall any Wyoming provider willing to meet the established terms and conditions be denied the right to enter into any written agreement").

3. *See, e.g.*, Tex. Civ. Prac. & Rem. Code § 88.002(f) (prohibits an MCO from dropping or refusing to renew a provider for advocating medically necessary treatment); *id.*, § 88.002(g) (prohibits an MCO from including indemnification clauses in contracts with providers that would hold it harmless for its own acts); *see also infra* at 8-9 (listing similar Kentucky statutes).

exclusive federal regulation of employee benefit plans has troubled this Court and lower courts almost since ERISA's enactment.

In this case, Petitioners have focused their argument on ERISA's insurance savings provision and assert that the Kentucky statute at issue, Ky. Rev. Stat. Ann § 304.17A-270, is not saved from ERISA § 514(a) preemption because it is not a statute that "regulates insurance." 29 U.S.C. § 1144(b)(2)(A). *Amici* disagree with this position, but, on a more fundamental level, *amici* believe that Petitioners have largely miscast the nature of the inquiry and, in doing so, run the risk of muddying even further the boundary of ERISA's preemptive scope. Avoidance of unnecessary regulatory gaps depends most importantly upon the scope of field preemption under ERISA § 514(a), which generally provides that ERISA supersedes state laws to the extent they "relate to" covered employee benefit plans. In contrast, reliance upon the insurance savings provision of ERISA § 514(b)(2)(A) to preserve state regulatory authority does so only to the extent plans and plan sponsors elect to purchase insurance as the funding mechanism for plan benefits. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 735 n.14 (1985). The consequence of *Metropolitan Life* is to significantly dilute the states' ability to regulate health care and other areas of traditional state concern. *See* U.S. Gen. Accounting Office, Employer-Based Managed Care Plans: ERISA's Effects on Remedies for Benefit Denials and Medical Malpractice 6 (1998) ("approximately 40 percent of insured people are enrolled in self-funded plans, plans that are free from state insurance regulation.").

Amici believe ERISA § 514 should be reexamined to establish properly the line between regulation of health care (and other areas of traditional state regulation) and the exclusively federal regulation of employee benefit plans.

In particular, *amici* propose that the Court refine its analysis of what it means for a state law to "relate to" an employee benefit plan. 29 U.S.C. § 1144(a). *Amici* suggest an analysis that will provide clearer guidance for the lower courts when faced with ERISA § 514(a) preemption issues and properly restrict field preemption to the area of ERISA's regulatory concerns.[4]

SUMMARY OF ARGUMENT

This case demonstrates the importance of a close examination of ERISA's text as well as its underlying structure and objectives when deciding whether a state law "relate[s] to" an employee benefit plan. Congress' goal in enacting ERISA was to provide: (1) disclosure and other safeguards with regard to the establishment, operation, and administration of employee benefit plans; and (2) minimum standards to ensure the equitable character of such plans and their financial soundness. 29 U.S.C. § 1001(a). ERISA's preemption provision, 29 U.S.C. § 1144(a), states that ERISA "shall supersede any and all State laws insofar as they . . . relate to any employee benefit plan." Petitioners, several Kentucky HMOs and their trade organization, along with their *amici*, have argued that ERISA § 514(a) preempts Kentucky's AWP statute, Ky. Rev. Stat. Ann § 304.17A-270, because the statute does not "regulate[] insurance" within the meaning of ERISA § 514(b)(2)(A), 29 U.S.C.

4. A Respondent and its supporting *amicus* are not limited to the "question presented" by the Petitioner, but rather may properly argue any ground to support the judgment that was raised in the court below. See Robert L. Stern, Eugene Gressman, Stephen M. Shapiro & Kenneth S. Geller, Supreme Court Practice 422 (8th ed. 2002). In this case, Respondent raised and the court below decided the "relate to" issue under ERISA § 514(a). *See Kentucky Ass'n of Health Plans, Inc. v. Nichols*, 227 F.3d 352, 357-64 (6th Cir. 2000). The *amici* are informed that Respondent will also argue the § 514(a) "relate to" issue in this Court.

§ 1144(b)(2)(A). In doing so, Petitioners largely have leapfrogged over the antecedent question of whether the Kentucky statute even "relate[s] to" employee benefit plans. *Id.*, § 1144(a).

Kentucky's AWP statute does not "relate to" employee benefit plans. Rather, it is one of myriad state laws that regulate health care. This Court has repeatedly indicated that, in the absence of a clear expression of congressional intent, federal statutes should not displace traditional state regulation of health care. ERISA contains no such clear expression of congressional intent. In fact, "[n]othing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *New York State Conf. Of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995).

An examination of ERISA reveals that it regulates employee benefit plans and the relationships those plans have with certain other entities, such as plan sponsors, plan fiduciaries, and plan participants and beneficiaries. ERISA § 514's "relate to" preemption provision should be construed to be congruent with ERISA's regulatory scope, an analysis that is consistent with general field preemption principles.

As Petitioners themselves stress, the Kentucky statute does not govern either employee benefit plans or the relationships those plans have with other ERISA-regulated entities. Instead, this statute regulates the relationship between physicians (and other health care professionals) and "health insurers" as defined by the Kentucky legislature. The Kentucky statute has, at most, the kind of "indirect economic effect" on employee benefit plans that this Court has held does not give rise to ERISA § 514(a) preemption. *Travelers*, 514 U.S. at 659. In addition to the fact that the Kentucky statute does not "relate to" an employee benefit plan, it also "regulates insurance" within the meaning of ERISA

§ 514(b)(2)(B) and therefore would be saved from ERISA § 514(a) preemption in any event.

For these reasons, *amici* urge this Court to affirm the judgment of the Sixth Circuit and reformulate its interpretation of ERISA § 514(a) preemption. This will fulfill ERISA's regulatory concerns, while better allowing states to continue to regulate other areas of state concern, including health care.

ARGUMENT

I. THE KENTUCKY STATUTE IS NOT PREEMPTED BY ERISA BECAUSE IT DOES NOT "RELATE TO" EMPLOYEE BENEFIT PLANS WITHIN THE MEANING OF ERISA § 514(a).

Petitioners and their *amici* gloss over the important question of whether the Kentucky statute "relate[s] to" employee benefit plans. 29 U.S.C. § 1144(a). *Amici* believe it does not. Instead, the state statute regulates health care — a traditional area of state concern. The Kentucky statute lies far afield from ERISA's regulatory scope and concerns.

A. The Kentucky statute is an economic regulation of health care.

Kentucky's AWP statute provides that "[a] health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer, including the Kentucky state Medicaid program and Medicaid partnerships." Ky. Rev. Stat. Ann § 304.17A-270. A "provider" or "health care provider" is defined to include physicians as well as other types of health care practitioners. *Id.*, § 304.17A-005(19).

Petitioners describe the effect of the statute as requiring them "to throw open their closed provider networks to any provider in the geographic area willing to abide by the terms of their network contracts." Pet. Brief at 4. Petitioners assert that:

> Because an HMO's ability to control costs and quality depends in large part on its ability to determine for itself the providers with network access, . . . the unavoidable consequence of the law[] is to drive up the costs of the health care services managed by HMOs and to affect their ability to regulate efficiently the quality of care offered by network providers.

Id. at 4-5. This increase in health care costs provided by HMOs is said ultimately to affect ERISA-governed employee benefit plans because some HMOs "contract[] with ERISA plans to enroll plan beneficiaries as direct subscribers in the HMO[, and some] also make their provider networks available to self-funded employee benefit plans, for which the HMOs provide only administrative services and bear no risk." *Id.* at 3. According to Petitioners, controlling access to their networks is "fundamental to the entire enterprise of managing the quality and costs of health care." *Id.*

As this argument shows, Kentucky's AWP statute is part of Kentucky's regulation of the economic relationships between physicians and other health care professionals on the one hand and HMOs and other insurers on the other. These economic relationships are "inextricably mixed" with the delivery of health care. *Pegram*, 530 U.S. at 229. Consequently, the state extensively regulates these relationships. *See, e.g.*, Ky. Rev. Stat. Ann. § 304.17A-350 (limiting the circumstances under which an insurer can delay payment on a claim to a health care provider); *id.*, § 304.17A-

525 (requiring insurer to establish standards for health care provider participation in a plan); *id.*, § 304.17A-560 (prohibiting insurer from inserting "most-favored-nation" provision in contract with health care provider); *id.*, § 304.17A-702 (establishing time frame in which insurer must pay health care provider's claims); *id.*, § 304.17A-728 (requiring insurer to disclose discounted fees in contract with health care provider and stating that failure to do so violates state's unfair claims settlement practices).

It should be clear that such state regulation of health care is not preempted by ERISA, entirely apart from the insurance savings provision of ERISA § 514(b)(2)(A). This Court has said that "[n]othing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Travelers*, 514 U.S. at 661. This Court has also held that "hospitals operated by ERISA plans are subject to the same laws as other hospitals." *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 808 (1997). This Court has indicated that preemption of state standards of reasonable medical care and medical malpractice should be avoided. *Pegram*, 530 U.S. at 236-37 (concluding that mixed eligibility and medical treatment decisions are not fiduciary decisions and therefore not within the ambit of ERISA).

In addition, this Court has held that the economic regulation of health care does not "relate to" employee benefit plans within the meaning of ERISA § 514(a), although such regulation may have an indirect, and even direct, economic effect on ERISA plans. *See Travelers*, 514 U.S. at 659 ("indirect economic effect" of hospital bill surcharges does not "relate to" an ERISA plan); *De Buono*, 520 U.S. at 815-16 (tax on hospital run by ERISA plan does not "relate to" plan despite direct impact on plan). Like the state laws in

Travelers and *De Buono*, the Kentucky statute is another health care regulation that may "increase[] the cost of providing benefits to covered employees [and so] will have some effect on the administration of ERISA plans." *De Buono*, 520 U.S. at 816. However, that effect by itself "simply cannot mean" that the statute "relate[s] to" ERISA plans and therefore is preempted by ERISA § 514(a). *Id.* As this Court recently stated, "although the added compliance cost to the HMO may ultimately be passed on to the ERISA plan, . . . such 'indirect economic effects,' are not enough to preempt state regulation even outside of the insurance context." *Rush Prudential HMO, Inc. v. Moran*, 122 S. Ct. 2151, 2167 n.11 (2002) (quoting *Travelers*, 514 U.S. at 659).

Notwithstanding this Court's statements and holdings in these cases, the court below held that the Kentucky statute does "relate to" employee benefit plans (and therefore would be preempted but for the insurance savings provision). This and similar holdings in the lower courts indicate the need for more clarity concerning the scope of "relate to" preemption under ERISA § 514(a). Preemption under § 514(a) operates as field preemption, with the states ousted of all regulatory authority over matters that "relate to" ERISA plans. Section 514(a) preemption therefore creates the potential for regulatory voids. This is not a problem where the regulatory gap was intended by Congress, such as leaving unregulated employer decisions whether to offer benefit plans, what types and levels of benefits to offer, and whether to purchase an MCO product or other insurance coverage to fund the benefits. It is a problem in areas where there is no indication that Congress intended to preclude the states from regulating, such as health care and the practice of medicine. There is a strong need, therefore, to better define the scope of "relate to" preemption and thereby specify the boundary of the preempted field.

This Court itself has expressed concern that the boundaries of ERISA § 514(a) "relate to" preemption are difficult to discern. *See, e.g., Travelers*, 514 U.S. at 655 ("we have to recognize that our prior attempt to construe the phrase 'relate to' does not give us much help drawing the line here.") (internal citation omitted); *De Buono*, 520 U.S. at 813 (same). It has also grappled repeatedly with how to derive substance from the limiting phrase "relate to" in a way that sets meaningful boundaries to the scope of § 514(a). As this Court stated in *Travelers*, "[if] 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes preemption would never run its course, for 'really, universally, relations stop nowhere.'" *Travelers*, 514 U.S. at 655 (internal citation omitted); *see also California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 329 (1997)

> if ERISA were concerned with any state action — such as medical-care quality standards or hospital workplace regulations — that increased costs of providing certain benefits, and thereby potentially affected the choices made by ERISA plans, we could scarcely see the end of ERISA's pre-emptive reach, and the words "relate to" would limit nothing.

Amici therefore propose a mode of analysis under ERISA § 514(a)'s preemption provision that more clearly separates the area occupied by ERISA's exclusive federal regulation from other areas of state regulation, such as health care and the practice of medicine. The basics of this approach may be simply stated. First, the scope of ERISA's regulatory domain should be identified based upon the structure and content of ERISA as a whole. Second, the scope of field preemption under ERISA § 514(a) should be held to be congruent with ERISA's regulatory domain. This approach is consistent with and gives meaningful content to § 514(a)'s statutory language. It also preempts state laws in areas where it makes

substantive sense to do so. At the same time, this approach respects "the separate spheres of governmental authority preserved in our federalist system," *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 19 (1987), and avoids the "unsettling" possibility that ERISA § 514(a) "results in the pre-emption of traditionally state-regulated substantive law in those areas where ERISA has nothing to say." *Dillingham*, 519 U.S. at 330.[5]

B. ERISA's domain is the employee benefit plan and those relationships between the plan and other entities and individuals that ERISA regulates.

ERISA's core focus is upon the establishment, content and operation of the "employee benefit plan" itself. In general, an employee benefit plan is the formal mechanism through which a plan sponsor (usually the employer) provides benefits to employees and related plan beneficiaries. This Court has said that ERISA's definitions of "employee welfare benefit plan" and "employee benefit plan" in 29 U.S.C. §§ 1002(1)(A) and 1002(3) are "ultimately circular." *Pegram*, 530 U.S. at 222. Nevertheless, these plans are fully described by the statute's legal requirements for a properly established plan.

In terms of the criteria applicable to both welfare benefit and pension plans, an ERISA plan must be "established and maintained pursuant to a written instrument." 29 U.S.C. § 1102(a)(1). That written instrument must identify at least one named fiduciary who has authority to control and manage the operation and administration of the plan, including the

5. As discussed below, the analysis advocated here concerns field preemption under ERISA § 514(a)'s "relate to" provision. It does not address or alter express or implied conflict preemption under ERISA, a matter this Court has held should be separately addressed.

responsibility to deny benefit claims. *Id.*, § 1102(a)(1), § 1133(2). Every employee benefit plan must also:

> (1) provide a procedure for establishing and carrying out a funding policy and method consistent with the objectives of the plan and the requirements of [ERISA], (2) describe any procedure under the plan for the allocation of responsibilities for the operation and administration of the plan (including any procedure described in section 1105(c)(1) of [ERISA]), (3) provide a procedure for amending such plan, and for identifying the persons who have authority to amend the plan, and (4) specify the basis on which payments are made to and from the plan.

29 U.S.C. § 1102(b).

An ERISA plan must provide a summary plan description ("SPD") to plan participants and beneficiaries, written in a manner calculated to be understood by the average participant, which contains a detailed list of information. *Id.*, § 1122; *see also* 29 C.F.R. § 2520.102-3 (listing plan contents that must be described in the SPD). An employee benefit plan must afford its plan beneficiaries some mechanism for internal review of a denial of benefits. *Id.*, § 1133(2). Moreover, an employee benefits plan is a distinct legal entity that "may sue or be sued" for plan benefits and other purposes. *Id.*, § 1132(d)(1).[6]

6. ERISA, of course, goes on to extensively regulate the administration of employee benefit plans by imposing, *inter alia*, reporting and disclosure requirements, 29 U.S.C. §§ 1021-31, participation and vesting requirements (except for employee welfare benefit plans), *id.*, §§ 1051-61, funding obligations (except for employee welfare benefit plans), *id.*, §§ 1081-86, administrative provisions and civil and criminal enforcement provisions, *id.*, §§ 1131-45, and various additional standards for group health plans, *id.*, §§ 1161-91. This is the heart of what ERISA does.

An important point illustrated by these statutory criteria is that an ERISA "employee benefit plan" must be distinguished from products offered by HMOs and other MCOs. These products are not ERISA plans but instead are commercial products that an MCO may sell to ERISA plans (as well as to other entities and individuals). These MCO products sometimes use the term "plan" or "health plan" in their name, but they are not ERISA plans. Rather, when purchased by an ERISA plan or plan sponsor, these products are the means for funding and delivering benefits to plan beneficiaries.

A given MCO may package and market a variety of managed care products (whose features often include covered services, designated providers and compensation for those providers) which are purchased and utilized by ERISA plans and others alike to provide benefits. Managed care products may be purchased by individuals or entities wholly apart from any employment relationship governed by ERISA. These products may have more "insurance-like" characteristics, or they may simply be rented access to some network of physicians or health care professionals. An ERISA plan itself may switch from one MCO product to another, or it can choose to provide benefits using different means. Or, the employer may elect to self-fund for one group of employees at one location but provide HMO coverage for another group of employees in a different location. The MCO products purchased by the ERISA plan may vary, but the ERISA plan remains the same unless formally amended in the manner specified by the plan.[7]

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7. The Court has said that "the agreement between an HMO and an employer who pays the premiums may . . . provide elements of a plan by setting out rules under which beneficiaries will be entitled to care." *Pegram*, 530 U.S. at 223. That is so, however, only where the ERISA plan adopts as plan terms the provisions of an HMO

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ERISA's regulatory domain includes more than the ERISA plan itself. ERISA also regulates the relationships between plans and other specified entities and individuals. Principally, these other entities and individuals are the "employer" or "plan sponsor," 29 U.S.C. § 1002(5), § 1002(16)(B), the plan "participant" or "beneficiary," 29 U.S.C. §§ 1002(7) and (8), the plan "administrator," 29 U.S.C. § 1002(16)(A), and plan "fiduciar[ies]." 29 U.S.C. § 1002(21)(A). Some courts have called employers, plan administrators, fiduciaries, participants, and beneficiaries "traditional ERISA entities." *See, e.g., Bullock v. Equitable Life Assur. Soc. of U.S.*, 259 F.3d 395, 399 (5th Cir. 2001).

ERISA imposes comprehensive decision-making duties on plan fiduciaries, 29 U.S.C. § 1104, imposes liability to the plan for a breach of those duties, *id.*, §§ 1105, 1109, and prohibits certain transactions between a plan and a plan fiduciary. *Id.*, § 1106(b). ERISA imposes obligations on the employer or plan sponsor to fund the plan and maintain records, *id.*, §§ 1059, 1082, 1083, prohibits the employer from using plan assets for its own benefit, *id.*, § 1103(c), and restricts the plan's ability to purchase the employer's securities. *Id.*, § 1107. The plan administrator, who may or may not be the plan sponsor, has a number of disclosure obligations, including the duty to file annual and other reports on behalf of the plan, *id.*, §§ 1021, 1023-24, as well as notices of significant reductions in benefit accruals. *Id.*, § 1054(h).

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product. Moreover, the terms of the HMO product that is available for purchase by an ERISA plan (or by any other person or entity) are those permitted by applicable state laws regulating insurance. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739-47 (1985) (ERISA does not preempt state insurance laws that regulate the terms of insurance policies which may be sold to ERISA plans); *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358, 376 (1999) ("insurers . . . [may not] displace any state regulation simply by inserting a contrary term in plan documents").

With regard to plan participants and beneficiaries, ERISA prescribes the plan's obligations to participants for the accrual and payment of plan benefits, *id.*, §§ 1054, 1056, creates a private right of action against the plan, *id.*, § 1132(a), and provides a participant with a right to a notice of denial of claim for benefits under the plan. *Id.*, § 1133.

To a much lesser extent, ERISA also addresses the relationship between plans and insurance companies. ERISA acknowledges that plans may provide welfare benefits to plan participants "through the purchase of insurance or otherwise." *Id.*, § 1002(1). ERISA obligates an insurance company that provides benefits under a plan or holds plan assets to provide certain information to the plan administrator for use in the plan's annual report. *Id.*, § 1023(a)(2)(A). The statute also establishes requirements for ensuring the adequacy of an insurer's assets when an insurance policy has been purchased for the benefit of participants in an employee pension benefit plan. *Id.*, §§ 1101(b), (c). And, in the context of group health plans, the Health Insurance Portability and Accountability Act of 1996, *id.*, §§ 1181-1191c, imposes various requirements on both health insurers and such plans with regard to disclosure, portability and limitation of any preexisting condition exclusions. *See also* 29 C.F.R. § 2520.102-3(q).

However, unlike the "traditional ERISA entities" such as beneficiaries, employers, and fiduciaries, ERISA does not presume that a relationship between an employee benefit plan and an insurer necessarily exists. Moreover, where a relationship between an insurer and a plan does exist, ERISA does not comprehensively regulate the relationship. Rather, ERISA cedes to the states via the insurance savings provision almost all the regulation of the insurer-employee benefit plan relationship. 29 U.S.C. § 1144(b)(2)(A).

C. Properly construed, the scope of "relate to" field preemption under ERISA § 514(a) is congruent with ERISA's domain.

ERISA § 514(a)'s "relate to" provision should be construed to preempt a field co-extensive with ERISA's regulatory domain — that is, state laws that primarily regulate either: (1) employee benefit plans (including their establishment, content, or administration); or (2) the relationships between plans and other entities and individuals that ERISA regulates. This construction gives meaning to the statutory term "relate to," because the preempted field encompasses more than state laws that regulate the plan itself. This construction also gives meaning to ERISA § 514(a)'s preemption provision as a whole, because the result is field preemption (rather than merely conflict preemption based upon specific statutory provisions). *Cf. Dillingham*, 519 U.S. at 335-36 (Scalia, J., concurring); *Egelhoff v. Egelhoff*, 532 U.S. 141, 152-53 (2001) (Scalia, J., concurring); *id.* at 153-54 (Breyer, J., dissenting).

For example, ERISA does not require employers to have employee benefit plans, nor does the federal statute "mandate what kinds of benefits employers must provide if they choose to have [an employee benefit] plan." *Pegram*, 530 U.S. at 226-27. Nevertheless, because ERISA § 514(a) preempts the field encompassed by ERISA's regulatory domain (which begins with the employee benefit plans itself), states may not mandate the benefits that such plans must provide. *See, e.g., Dillingham*, 519 U.S. at 328. Similarly, because ERISA's domain also encompasses the relationship between the plan and plan administrator, a state law that focuses on any aspect of that relationship "relate[s] to" the plan — regardless of whether ERISA itself addresses that specific part of the relationship. *See, e.g., UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358, 378-79 (1999) (state law making the "policyholder-employer the agent of the insurer.").

The "relate to" preemption analysis offered by *amici* reinforces the statutory objectives as articulated in ERISA § 1001. It preserves for exclusive federal regulation those areas that ERISA does regulate, but does not threaten to create regulatory voids beyond ERISA's regulatory scope. This analysis also materially assists in clarifying — for ERISA plan designers, for state legislatures, and for lower courts — the scope of ERISA § 514(a)'s field preemption. The boundaries of the preempted field are delimited by ERISA's regulatory scope. While *amici* do not pretend that this analysis will yield easy answers for every preemption issue, they do contend that it will aim the focus of inquiry in the correct direction.

Three additional points concerning this suggested construction of ERISA § 514(a) are also pertinent. First, the analysis makes sense of the insurance savings provision of ERISA § 514(a)(2)(A), which "reclaims a substantial amount of ground" that ERISA § 514(a) preempts by saving state laws that "regulate[s] insurance." *Rush Prudential*, 122 S. Ct. at 2158. ERISA regulates the relationship between plans and insurers much less intensively than it regulates the relationship between plans and the "traditional ERISA entities," such as plan sponsors, fiduciaries and beneficiaries. ERISA's regulation also contrasts sharply with the "extensive state regulation" of insurance, including group health insurance. *See Metropolitan Life*, 471 U.S. at 728 & n.2 (identifying state laws governing solvency, the qualifications of management, claims practices, rates, mandated-benefits, grace periods, and conversion privileges as examples of categories of state laws regulating insurance). Nonetheless, ERISA does at times address insurers and insurance and their relationship with employee benefit plans. *See* Part IB, *supra*. Thus, the insurance savings provision is necessary to ensure that state insurance regulation is not caught in the field preemption of ERISA § 514(a), a result that would leave the

plan-insurer relationship largely in a regulatory void. *See FMC Corp. v. Holliday*, 498 U.S. 52, 64 (1990) ("the saving clause . . . protect[s] state insurance regulation of insurance contracts purchased by employee benefit plans.").

Second, *amici*'s proposed construction of ERISA § 514(a)'s "relate to" provision concerns only field preemption under that statutory section. It does not alter traditional conflict preemption principles. A state statute is still preempted when it prevents or frustrates the accomplishment of ERISA's objectives (or when compliance with both the state and federal regimes is impossible. *See Geier v. American Honda Motor Co.*, 529 U.S. 861, 873-74 (2000) (calling difference between types of conflict preemption only "terminological")). This Court has used traditional conflict preemption principles to decide a number of ERISA preemption cases independently of field preemption under ERISA § 514(a). *See, e.g., Boggs v. Boggs*, 520 U.S. 833, 841 (1997) ("We can begin[] and . . . end[] the analysis by simply asking if state law conflicts with the provisions of ERISA or operates to frustrate its objects."); *John Hancock Mutual Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99 (1993) ("State law governing insurance generally is not displaced, but 'where [that] law stands as an obstacle to the accomplishment of the full purposes and objectives of Congress,' federal preemption occurs."); *Ingersoll-Rand Co. v. McClendon*, 489 U.S. 133, 142 (1990) (state cause of action conflicts with ERISA cause of action).

Third, the construction of ERISA § 514(a)'s "relate to" provision suggested here is consistent with the results (albeit not necessarily the reasoning) of most or all of the Court's preemption decisions under ERISA § 514(a). For example, state laws that regulate plan benefits or other content of ERISA plans are preempted by § 514(a), as held in cases such as *FMC Corp.*, 498 U.S. at 60 (Pennsylvania statute

preempted because it "prohibits plans from being structured in a manner requiring reimbursement in the event of recovery from a third party"); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983) (New York statutes "which prohibit[] employers from structuring their employee benefit plans in a manner that discriminates on the basis of pregnancy" and which "require[] employers to pay employees specific benefits" are preempted); and *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524-25 (1981) (New Jersey statute prohibiting set-off of workers' compensation awards allowed by ERISA, 29 U.S.C. § 1053(a), is preempted). Similarly, state laws that regulate benefits administration "relate to" an employee benefit plan under § 514(a), *see Egelhoff*, 532 U.S. at 147-48 (Washington statute "govern[ing] the payment of benefits, a central matter of plan administration" preempted because it "bind[s] ERISA plan administrators to a particular choice of rules for determining beneficiary status"), as do laws that regulate the relationship between the beneficiary and the plan, *see, e.g., UNUM*, 526 U.S. at 367 (notice-prejudice rule, which allows claim filed out of time unless delay has caused prejudice, "relate[s] to" plan).[8]

At the same time, statutes that regulate relationships between ERISA plans and parties not regulated by ERISA fall outside the scope of ERISA field preemption under *amici*'s proposed construction of § 514(a). *See, e.g., Mackey*, 486 U.S. at 833 ("lawsuits against ERISA plans for run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan" are not preempted). Likewise, laws of general application that do not regulate employee benefit plans but may have some economic or other "effect" on them are not within the field preempted by § 514(a). *See Travelers*, 514 U.S. at 659;

8. In *UNUM*, the state law was nevertheless saved from preemption by ERISA § 514(b)(2)(A)'s savings provision for state insurance laws.

Dillingham, 519 U.S. at 334; *De Buono*, 520 U.S. at 815-16. Areas of state law, such as medical decisionmaking, are even further afield from ERISA's regulatory domain. *Cf. Pegram*, 530 U.S. at 236-37 (mixed eligibility and medical treatment decisions are not within ERISA's regulatory domain).[9]

In sum, focusing the ERISA § 514(a) analysis on whether the state law primarily regulates the establishment, content or administration of an employee benefit plan or its relationships with other ERISA-regulated entities gives meaningful content to § 514(a). It also defines the scope of ERISA field preemption in ways that make sense in terms of the Act viewed as a whole, while leaving States able to regulate within their traditional "separate sphere[] of governmental authority." *Fort Halifax*, 482 U.S. at 19. By more clearly defining what lies within the field preempted

9. *Amici*'s proposed construction of § 514(a) is difficult to reconcile with the part of the opinion in *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988), which ruled that Georgia's antigarnishment statute "relate[s] to" employee benefit plans (and therefore falls within the preempted field) merely because it "refers to" such plans. *Id.* at 829-30. On the other hand, a benefit of *amici*'s analysis is that it provides a more substantive rule of decision (and one that is more consonant with ERISA's objectives) than simply whether or not a state statute *mentions* ERISA plans. *See, e.g., Prudential Ins. Co. v. National Park Medical Ctr., Inc.*, 154 F.3d 812, 823-24 (8th Cir. 1998) (Arkansas Any Willing Provider statute held preempted because it *exempted* self-funded plans from its requirements); *Kentucky Ass'n of Health Plans v. Nichols*, 227 F.3d 352, 360 (6th Cir. 2000) (same "relate to" reasoning by court below). (Even under *Mackey*'s "reference to" analysis, the result in *National Park Medical Ctr.*, makes no sense. That case held that the Any Willing Provider statute "relate[d] to" ERISA plans based solely on a statutory provision exempting such plans from coverage. But the court then held the entire statute preempted — whereas ERISA § 514(a) plainly states that state laws are preempted only "*insofar as*" they relate to employee benefit plans. 29 U.S.C. § 1144(a) (emphasis added)).

by § 514(a)'s "relate to" provision, the areas of state law that lie outside the preempted field, such as health care and the practice of medicine, can be more easily determined. The approach also makes sense of the insurance savings provision, leaves conflict preemption under ERISA unaffected, and is generally consistent with the results in the Court's previous § 514(a) preemption cases.

D. State laws like the Kentucky statute, which regulate health care, are not within ERISA's domain and therefore are not within the field preempted by ERISA § 514(a).

The Kentucky AWP statute is not preempted by ERISA § 514(a) under the construction advocated by *amici*. First, the AWP statute does not regulate employee benefit plans. As discussed in Part IB, *supra*, the product offered for sale by an MCO (or other insurer) is not the ERISA plan. The record in this case also confirms that conclusion. The exemplar "Certificate of Coverage," *see* Joint App. 21a, is not an ERISA plan. The exemplar itself distinguishes between the "Certificate" and the "Group Plan" in its Definitions section, Joint App. 24a, 26a, making clear that the ERISA plan is a written instrument apart from the Certificate of Coverage. In addition, the Certificate of Coverage does not even conform to the Department of Labor's requirements for an SPD. *See* 29 C.F.R. § 2520.102-3 (listing required contents of SPD).[10]

10. For example, the Certificate of Coverage does not identify the employer identification number (EIN) assigned to the plan sponsor, 29 C.F.R. § 2520.102-3(c), the type of administration of the plan, *id.*, § 2520.102-3(e), the name, address and telephone number of the plan administrator, *id.*, § 2520.102-3(f), and the designated agent for service of process, *id.*, § 2520.102-3(g).

Second, the Kentucky AWP statute regulates the relationship between the MCO (insurer) and health care service provider and operates independently of any connection to an ERISA plan. Petitioners and their *amici* repeatedly make this point. *See, e.g.*, Pet. Brief at 11 ("AWP laws . . . regulate non-insurance contracts between non-insurers and insurers."); *id.* at 28 (contracts governed by these statutes are "between insurers and third-party providers — pharmacies, doctors, hospitals, and so on."); Community Health Partners *Amicus* Brief at 11 ("The form of AWP statutes relates not to the insurer-insured relationship, but instead to the insurer-provider relationship."). The relationship between insurer and service provider is not a relationship regulated by ERISA. For this reason as well, the Kentucky statute does not "relate to" employee benefit plans under ERISA § 514(a).[11]

11. As discussed in Part IA, *supra*, this particular type of state statute also should not be preempted under the Court's current "relate to" analysis. First, the state statute regulates health care, a type of regulation which the Court has repeatedly indicated is not within the field preempted by ERISA § 514(a). Second, Petitioners' argument is that the statute "relate[s] to" ERISA plans because it "'bear[s] indirectly but substantially on all insured benefits plans' by precluding them from purchasing medical coverage from HMOs with limited provider networks." Pet. Brief at 12. This argument is analytically identical to the failed argument in *Travelers* that the "indirect economic effect" of the surcharge on hospital bills for commercial insurers "related to" employee benefit plans because it prevented those plans from purchasing medical coverage from commercial insurers without being subject to the surcharge. *Travelers*, 514 U.S. at 659. Like that state regulation in *Travelers*, Petitioners argue the AWP statute "drive[s] up the cost of the health care services managed by HMOs," Pet. Brief at 5, and those costs may be passed on to ERISA-governed employee benefit plans. Moreover, the AWP statute's alleged effect on ERISA plans is even more attenuated than the "direct impact" of the hospital revenue tax in *De Buono*, where the ERISA fund argued that the tax, in essence, prevented the fund's

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This conclusion that a statute governing the relationship between a physician and an insurer does not "relate to" employee benefit plans is also supported by several lower court decisions. Courts have almost uniformly held that ERISA does not preempt state law misrepresentation claims by a physician against an MCO arising from the MCO's wrongful failure to pay promised benefits to the physician, because such a claim does not "relate to" an employee benefit plan. "State law claims brought by health care providers against plan insurers too tenuously affect ERISA plans to be preempted by the Act." *Lordmann Enterp., Inc. v. Equicor, Inc.*, 32 F.3d 1529, 1533 (11th Cir. 1994).[12] *See also Washington Physicians Serv. Ass'n v. Gregoire*, 147 F.3d 1039, 1045 (9th Cir. 1998) (AWP statute "is merely one of many state laws that regulates one of many products that an employee benefit plan might choose to buy" and so does not "relate to" ERISA plan).

Under the reasoning of the court below, the Kentucky statute could be viewed as also regulating the relationship

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hospital from obtaining as much revenue as it would without the imposition of the tax. Despite the direct impact in *De Buono*, this Court held that the tax statute did not "relate to" an ERISA plan. 520 U.S. at 815-16; *see also Travelers*, 514 U.S. at 662 ("cost uniformity was almost certainly not an object of pre-emption"); *Dillingham*, 519 U.S. at 334 (rejecting preemption challenge to state law that "altered the incentives, but [did] not dictate the choices, facing ERISA plans").

12. *Accord Cypress Fairbanks Medical Center Inc. v. Pan-American Life Ins. Co.*, 110 F.3d 280 (5th Cir. 1997); *In Home Health, Inc. v. Prudential Ins. Co. of America*, 101 F.3d 600, 605-06 (8th Cir. 1996); *Hospice of Metro Denver, Inc. v. Group Health Ins. of Oklahoma, Inc.*, 944 F.2d 752, 756 (10th Cir. 1991); *Reichmister v. United Healthcare of the Mid-Atlantic, Inc.*, 93 F. Supp. 2d 618 (D. Md. 2000); *National Rehabilitation Hosp. v. Manpower Int'l, Inc.*, 3 F. Supp. 2d 1457, 1460 (D.D.C. 1998).

between the insurer and the employee benefit plan. That is, in the Sixth Circuit's view, the Kentucky statute increases the universe of the health care providers that are available to the plan's participants and beneficiaries, and the court saw this effect as a benefit coverage requirement. Under the construction of § 514(a) proposed by *amici*, there is no need to address that issue. The Kentucky statute directly and primarily regulates the relationship between the insurer and the health care service provider. The statute therefore does not relate to employee benefit plans, and so is not within the field preempted by ERISA § 514(a). It is, however, also true that if (or to any extent that) the Kentucky statute were deemed to regulate insurance policy benefits, it would by definition be a state law regulating insurance. The statute therefore would necessarily be saved from field preemption by ERISA § 514(b)(2)(A)'s savings provision for state laws that regulate insurance.

II. THE KENTUCKY STATUTE ALSO "REGULATES INSURANCE" WITHIN THE MEANING OF ERISA § 514(b)(2)(A).

The Kentucky statute also is saved from preemption because it "regulates insurance." 29 U.S.C. § 1144(b)(2)(A). This Court has taken pains recently not to "plot the exact perimeter of the savings clause." *Rush Prudential*, 122 S. Ct. at 2159. Instead, this Court has described its savings provision analysis as "supple" and stressed that the three McCarran-Ferguson factors it often references are simply relevant "guideposts, not separate essential elements . . . that must each be satisfied" for a state law to be saved. *UNUM*, 526 U.S. at 374. "[A]s long as providing insurance fairly accounts for the application of state law, the saving clause may apply." *Rush Prudential*, 122 S. Ct. at 2160.

Amici suggest that the Court's decisions in *Department of Treasury v. Fabe*, 508 U.S. 491 (1993) and *Barnett Bank v. Nelson*, 517 U.S. 25 (1996), demonstrate that, outside the

antitrust context, strict adherence to the three factors set forth in *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982) may lead to an overly narrow view of laws which "regulate insurance" within the meaning of the McCarran-Ferguson Act. 15 U.S.C. § 1012. The Court in *Fabe* stated that "the primary purpose of the insurance company" is "the payment of claims made against policies." *Fabe*, 508 U.S. at 506. A statute which "serve[s] to ensure that, if possible, policyholders ultimately will receive payment on their claims" is one that has been "enacted for the purpose of regulating the business of insurance." *Id.* This Court in *Rush Prudential* acknowledged that the insurance savings provision in ERISA § 514(b)(2)(A) has a similar breadth. 122 S. Ct. at 2160 ("as long as providing insurance fairly accounts for the application of state law, the savings clause may apply.")

In early ERISA insurance savings provision cases, this Court incorporated the part of the analysis of the McCarran-Ferguson Act that addressed exemption from antitrust liability. *Metropolitan Life*, 471 U.S. at 742-43 (relying on *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979) and *Pireno*). More recently, however, the Court acknowledged that the two clauses in Section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. § 1012(b), have different scopes. "[T]he first clause of § 2(b) was intended to further Congress' primary objective of granting the states broad regulatory authority over the business of insurance. The second clause accomplishes Congress' secondary goal, which was to carve out only a narrow exemption for 'the business of insurance' from the federal antitrust laws." *Fabe*, 508 U.S. at 505 (citing *Royal Drug*, 440 U.S. at 218 n.18). This Court has stated that the first clause is "not so narrowly circumscribed" as the second clause dealing with antitrust liability. *Id.* at 504. When interpreting the first clause of Section 2(b), state laws that "possess the 'end, intention, or aim' of adjusting, managing, or controlling the business of insurance" also fall within the category of laws that regulate the business of insurance. *Id.* at 505.

It would be a mistake, therefore, to rely exclusively on cases construing the McCarran-Ferguson Act in the context of potential exemption from antitrust liability, such as *Royal Drug* and *Pireno*, when determining the perimeter of what constitutes a regulation of the business of insurance. *Id.* at 505. Under *Fabe*'s broader analysis, "state laws enacted 'for the purpose of regulating the business of insurance' do not yield to conflicting federal statutes unless a federal statute specifically requires otherwise." *Id.* at 507. Because Kentucky's AWP statute "adjust[s], manag[es], or control[s] the business of insurance," *id.* at 505, by regulating an HMO (or other "health insurer")'s ability to contract (or not contract) with a physician or health care provider, it is a law enacted for the purpose of regulating the business of insurance. The statute also, at least indirectly, has the potential to alter the composition of physicians a health insurer must include in its network. Under *Fabe*, the McCarran-Ferguson Act would dictate that the Kentucky statute is not preempted because ERISA does not "specifically require[]" preemption. *Id.* at 507.

In *Barnett Bank*, the Court construed the "business of insurance" from a different perspective. There, the Court focused on the exception to the McCarran-Ferguson Act's anti-preemption rule that applies when Congress has enacted a federal statute that "specifically relates to the business of insurance." 15 U.S.C. § 1012(b). The federal statute in question, 12 U.S.C. § 92, allows national banks under certain circumstances to sell insurance as agents on behalf of insurance companies. *Barnett Bank*, 517 U.S. at 28. Despite the fact that a Florida statute prohibited national banks from selling insurance in Florida, *id.* at 29, the Court held that the federal statute applied because it regulates the "business of insurance." *Id.* at 39. While the Court said that the federal statute "affect[ed] the relation of insured to insurer and the spreading of risk," *id.*, it made no mention of the third factor in the *Pireno* test — limitation of the practice to entities within the insurance industry. Moreover, the Court focused on the statute's emphasis on "industry-specific selling

practices," such as the solicitation and sale of insurance, collection of premiums and receipt of commissions, as the basis for its determination that the statute related to "the business of insurance." *Id. Barnett Bank* indicates that "the business of insurance" according to the McCarran-Ferguson Act includes the business practices of insurance agents, not simply insurers, and does not focus exclusively on the spreading of risk between insurer and insured. In fact, since the insurer, not the insurance agent, presumably accepts the risk from the insured, it seems that 12 U.S.C. § 92 spreads risk at most in nominal terms. Kentucky's AWP statute provides for risk-spreading at least as much as 12 U.S.C. § 92 because it shifts the increased cost associated with an insured obtaining medical services from a physician outside the HMO's limited provider network from the insured to the HMO. According to *Barnett Bank*, this is sufficient to conclude that the AWP statute regulates the "business of insurance."

Under the broader analysis set forth in *Fabe* and *Barnett Bank*, as well as for the reasons set forth in the Solicitor General's *amicus* brief and Respondent's brief, the Kentucky statute "regulates insurance" and is saved from preemption.

CONCLUSION

Refocusing the ERISA § 514(a) preemption analysis on the "employee benefit plan" and the plan's relationships with other ERISA-regulated entities will provide the Court with a more useful method of analysis than the current "relate to" preemption analysis. *Amici*'s proposed analysis adheres to the statutory text as well as the objectives of both ERISA's substantive provisions and its preemption provisions. It also harmonizes the holdings of almost all of the Court's prior ERISA § 514(a) precedents. Employing *amici*'s suggested analysis in this case, Kentucky's AWP statute clearly is outside the field preempted by ERISA § 514(a).

For all of the foregoing reasons, the judgment below should be affirmed.

Respectfully submitted,

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KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., *et al.*,

Petitioners,

v.

JANIE MILLER, COMMISSIONER, KENTUCKY DEPARTMENT OF INSURANCE,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

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QUESTION PRESENTED

Whether Kentucky's Any Willing Provider statute is preempted by ERISA if it does not relate to employee benefit plans or, is it saved from preemption because it regulates the business of insurance by regulating the practice of medicine?

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BRIEF *AMICUS CURIAE*

INTEREST OF THE *AMICUS CURIAE*[1]

The American College of Legal Medicine ("ACLM") has been in existence for 43 years and is an educational, non-profit organization with over 1300 members. It is the only organization of its kind in the sense that the majority of its members hold dual degrees in medicine and in law. Its membership also consists of attorneys, physicians, nurses, those in health care administration, in government service and those who hold full time academic positions in health care and health care law.

The mission of the ACLM is to educate, train and advance dialogue and discussion for those who have a sustained interest in issues at the crossroads of law, medicine and health care law. This includes promoting the administration of justice and assisting jurists in issues, such as the ones presented in this case.

SUMMARY OF ARGUMENT

Kentucky's Any Willing Provider ("AWP") statute is not preempted by ERISA because it does not relate to an employee benefit plan ("EBP"). If this Court determines that the statute does relate to an EBP, the statute is saved

[1] Petitioners and respondent have filed global consents to the filing of all *amicus* briefs in this case. No counsel for a party authored this brief in whole or in part. No persons or entities other than the *amicus* made a monetary contribution to the preparation or submission of this brief.

from preemption because it regulates the business of insurance by regulating the practice of medicine.

The AWP statute does not relate to an EBP because it does not have a connection with, or a reference to, an EBP sufficient to trigger preemption. There is no connection because the statute does not directly affect an EBP nor does it bear indirectly but substantially on an EBP. There is no reference to an EBP sufficient to trigger preemption because the statute does not act immediately and exclusively on an EBP nor is the existence of an EBP essential to the law's operation.

Further, in the alternative, the AWP statute is saved from preemption because the statute regulates the business of insurance by regulating the practice of medicine. The AWP statute regulates the business of insurance because it satisfies the common-sense enquiry as well as an analysis of the three McCarran-Ferguson criteria that are used to assess whether a statute is saved from ERISA preemption. The AWP statute regulates the practice of medicine because it counteracts the scheme of assigning too many patients to any one doctor, which can create a high patient volume medical practice. The scheme of restricting physician membership and limiting the number of doctors in a health insurance network can increase the patient to physician ratio in individual physician practices. This can result in deleterious consequences for patients because any one patient may not receive the necessary attention, care and treatment by reasonable medical standards. The AWP statute also promotes continuity of patient care because under the statute, health insurers cannot deny membership to a doctor who wants to join a health insurer to which his patient has transferred. Continuity of care preserves the patient-physician

relationship, which has a salutary effect on the health care of patients. This scheme is subject to regulation by Kentucky under its police powers.

ARGUMENT

I. KENTUCKY'S AWP STATUTE IS NOT PREEMPTED BY ERISA BECAUSE IT DOES NOT "RELATE TO" AN EMPLOYEE BENEFIT PLAN.

Kentucky's AWP statute is only preempted by ERISA if it meets ERISA's express preemption provision, § 514(a), 29 U.S.C. § 1144(a). Section 514(a) provides in pertinent part:

> . . . this chapter shall supersede any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan. . . .

The Sixth Circuit found Kentucky's AWP statute preempted by § 514(a) because it did "relate to" an EBP. *Ky. Assoc. of Health Plans, Inc. v. Nichols*, 277 F.3d 352, 363 (6th Cir. 2000). The Petitioners' Brief claims there is no serious dispute that Kentucky's AWP laws "relate to" EBPs. (Brief at p. 12.) However, ACLM submits the Sixth Circuit erred in this determination and this Court should find that Kentucky's AWP statute is not preempted by § 514(a) because it does not "relate to" an EBP.

This Court has addressed preemption claims with the starting presumption that Congress does not intend to supplant state law. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645, 654-55 (1995). Traditional preemption analysis begins with the text of the provision in question and moves on to the structure and purpose of the Act in which it occurs. *Id.* at 655. This Court observed in *Travelers* that

the language of § 514(a) is not particularly helpful in deciding preemption issues.

> If "relate to" were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes preemption would never run its course, for "[r]eally, universally, relations stop nowhere,"
> . . .

514 U.S. at 655.

To determine whether a law "relates to" an EBP, this Court has formulated a two part test under which a "law 'relate[s] to' a covered employee benefit plan for purposes of § 514(a) if it [1] has a *connection with* or [2] *reference to* such plan." *California Div. of Labor Standards v. Dillingham Constr. N.A., Inc.*, 519 U.S. 316, 324 (1997) (internal quotations and citations omitted) (emphasis added). A careful analysis of Kentucky's AWP statute finds that it does not meet either of these prongs and therefore, is not preempted by ERISA.

A. Kentucky's AWP statute does not have a connection with an employee benefit plan.

The ACLM submits that Kentucky's AWP statute does not have a "connection with" an EBP sufficient to trigger ERISA preemption because it is does not directly affect any EBP, nor bear indirectly, but substantially, on any EBP.

1. Kentucky's AWP law does not directly affect any employee benefit plans.

In *Travelers*, this Court began its analysis of the "connection with" test by noting that: "For the same reasons that infinite relations cannot be the measure of preemption, neither can infinite connections." *Id.* at 656.

This Court found that it "must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.* In analyzing preemption this Court has noted several different purposes for ERISA.

In *Travelers,* this Court found Congress intended § 514(a),

> "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . , [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction."

Id. at 657-658, citing *Ingersoll-Rand*, 498 U.S., at 142.

In *Dillingham Construction*, this Court cited *Massachusetts v. Morash*, 490 U.S. 107, 115 (1989) for the finding that:

> In enacting ERISA, Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds. To that end, it established extensive reporting, disclosure, and fiduciary duty requirements to insure against the possibility that the employee's expectation of the benefit would be defeated through poor management by the plan administrator.

519 U.S. at 326-327.

Certainly, this latter finding of congressional purpose is more consistent with ERISA's full name – Employee Retirement Income Security Act. However, Kentucky's AWP law is not directly related to either purpose.

In *Travelers,* this Court stated it had no problem finding the "relates to" test was met when state laws "mandated employee benefit structures or their administration." 514 U.S. at 657. The examples of such cases cited by this Court included: *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983) (New York law that required employers to provide certain benefits for pregnancy); *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), (Pennsylvania law that prohibited employer plans to subrogate their employee's claims from a liable third party); and *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981) (New Jersey law that prevented plans from calculating benefits using a method that was permitted by federal law). The common thread running through all of these cases was that the state had passed a statute, which *directly* required a plan to take (or not to take) certain action with regard to the provision of its benefits.

Kentucky's AWP law does not conflict with the goals of ERISA because it does not require any *employer* providing an EBP to do anything. It simply requires that all health insurance providers operating in Kentucky meet certain requirements. The analysis of this issue shows how the Petitioners miss a fundamental point.

As this Court noted in *Pegram v. Herdrich*, 530 U.S. 211, 227 (2000), **"The HMO is *not* the ERISA plan, . . ."** *Id.* (Emphasis added.) Applying this fundamental principle

to Kentucky's AWP statute finds that it is not preempted by ERISA.

Kentucky's AWP statute does not directly affect any EBPs that are covered by ERISA. No Kentucky employer is forced by this statute to offer a particular type of health care coverage as a benefit (or even any such coverage at all). If an employer does not offer health care coverage as a benefit the employer is not affected by the statute. If an employer offers a self-funded plan the employer is not affected by the statute. If an employer does purchase some type of health insurance benefits for its employees it is not told what type of benefits it must provide. Instead, the employer only finds when shopping for a health insurer that all of the health insurers who have sought the privilege of doing business in Kentucky have to comply with this statute.[2]

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[2] This position has been taken by many of the legal commentators examining this issue. *See*: William J. Bahr, *Although Offering More Freedom to Choose, "Any Willing Provider" Legislation is the Wrong Choice*, 45 U.Kan.L.Rev. 557, 582 (1996) (Any willing provider statutes do not regulate ERISA plans because there is only an indirect effect on ERISA plans and does not prevent a uniform administration of benefit plans.); Karen A. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Preemption*, 13 Yale J.Reg. 255, 331 (1996) ("Even if provided by the entity which also provides administration of plans for employers, the selection of network physicians should not be characterized as administration of an ERISA plan.); Justin Goodyear, *What is an Employee Benefit Plan?: ERISA Preemption of "Any Willing Provider" Laws After Pegram*, 101 Colum. L. Rev. 1107 (2001) (State laws that regulate the relationship between managed care organizations and health care providers should not be preempted by ERISA.); Dianne McCarthy, *Narrowing Provider Choice: Any Willing Provider Laws After New York Blue Cross v. Travelers*, 23 Am. J.L. & Med. 97, 107-108 (1997) ("Like the surcharges analyzed in New York

(Continued on following page)

Thus, any of the burdens imposed by Kentucky's AWP statute fall not on EBPs, but only on the health insurance companies who seek to do business in Kentucky by offering health insurance to EBPs. Because the HMO is not the ERISA plan, the AWP statute does not directly affect the ERISA plan.

2. Kentucky's AWP statute does not have an indirect, but substantial effect on any ERISA plans sufficient to find pre-emption.

As shown, Kentucky's AWP law is not preempted because it does not directly affect any ERISA plans. The Petitioners apparently concede this point because their Brief does not argue that the AWP statute directly affects ERISA plans. Instead, the Petitioners argue that AWP laws "bear indirectly but substantially on all insured benefit plans by precluding them from purchasing medical coverage from HMOs with limited provider networks." (Petitioners' Brief, p. 12.)

However, that argument would leave every Kentucky statute related to the provision of health care subject to ERISA preemption. For example, Ky. Rev. Stat. Ann. § 311.571 requires individuals to meet certain qualifications to be licensed physicians. Using the Petitioners' "analysis", this statute is preempted by ERISA, because it bears indirectly but substantially on all EBPs by precluding them from purchasing medical coverage from HMOs that use physicians who graduated from unaccredited schools. The absurdity of such a result is the reason this Court has recognized that a mere indirect, economic effect on an ERISA plan is not enough to preempt state law.

Blue Cross, "Any Willing Provider" laws indirectly affect ERISA plans, "Any Willing Provider" statutes neither function as a regulation of the plan itself, nor preclude uniform administrative practice or the provision of a uniform interstate benefit package. Furthermore, "Any Willing Provider" laws do not thwart the purpose of ERISA – to ensure that employee benefits plans are not required to alter their structure in response to individual state laws.")

In *Travelers*, this Court modified the "connection with" test by asking whether the law brought about an indirect economic effect that merely affected the rates charged by plans as opposed to the choices made by plan administrators. This Court found that "An indirect economic influence, however, does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself. . . ." Instead, "It simply bears on the costs of benefits and the relative costs of competing insurance to provide them." 514 U.S. at 659-660. Further, this Court noted in *Travelers*:

> Indeed, to read the pre-emption provision as displacing all state laws affecting costs and charges on the theory that they indirectly relate to ERISA plans that purchase insurance policies or HMO memberships that would cover such services would effectively read the limiting language in § 514(a) out of the statute, a conclusion that would violate basic principles of statutory interpretation and could not be squared with our prior pronouncement that "[p]re-emption does not occur . . . if the state law has only a tenuous, remote, or peripheral connection with covered plans, as is the case with many laws of general applicability." *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S., at 130 n.1,

113 S.Ct., at 583 n.1 (internal quotation marks and citations omitted).

514 U.S. at 661.

Thus, in finding that the statute in issue was not preempted, this Court held:

> In sum, cost uniformity was almost certainly not an object of pre-emption, just as laws with only an indirect economic effect on the relative costs of various health insurance packages in a given State are a far cry from those "conflicting directives" from which Congress meant to insulate ERISA plans. See 498 U.S., at 142, 111 S.Ct., at 484. Such state laws leave plan administrators right where they would be in any case, with the responsibility to choose the best overall coverage for the money. We therefore conclude that such state laws do not bear the requisite "connection with" ERISA plans to trigger pre-emption.

514 U.S. at 662.

This Court adopted the same rationale in *Dillingham* and found the prevailing wage statute in issue was not preempted because:

> The wages to be paid on public works projects and the substantive standards to be applied to apprenticeship training programs are, however, quite remote from the areas with which ERISA is expressly concerned – "'reporting, disclosure, fiduciary responsibility, and the like.'"

519 U.S. at 331 (citations omitted).

The principle that indirect economic effects of a state statute are not sufficient to trigger ERISA preemption was articulated in *Washington Physicians Service Association*

v. Gregoire, 147 F.3d 1039 (9th Cir. 1998), which upheld a Washington law that mandated the inclusion of all categories of providers. In rejecting ERISA preemption, the court held:

> The mere fact that many ERISA plans choose to buy health insurance for their plan members does not cause a regulation of health insurance automatically to "relate to" an employee benefit plan – just as a plan's decision to buy an apple a day for every employee, or to offer employees a gym membership, does not cause all state regulation of apples and gyms to "relate to" employee benefit plans.

Id. at 1043.

This analysis is bolstered by the fact that ERISA is totally silent on this issue. This Court noted in *Dillingham*, "A reading of § 514(a) resulting in the pre-emption of traditionally state-regulated substantive law in those areas where ERISA has nothing to say would be 'unsettling'." 519 U.S. at 331 (citations omitted). Because there is no conflict between the language of ERISA and Kentucky's AWP statute, it does not directly affect any EBPs.

Requiring health care insurers who have sought the privilege of doing business in Kentucky to include providers who are willing and able to meet all of their contractual requirements does not require EBPs to structure their benefits or conduct their internal affairs in any particular way. The AWP statute does not prohibit EBPs from offering coverage through a preferred provider organization or specify the terms of the provider contracts. The AWP statute does not impair a plan sponsor's ability to offer the same benefits to employees in different states. It does not require any ERISA plan to pay any benefit, any level of

benefit, or any particular amount of a patient's medical bill. In sum, it does not impose *any* substantive requirements on ERISA plans.

Just as this Court in *Dillingham* found that California's prevailing wage statute for contractors did " . . . not dictate the choices facing ERISA plans." 519 U.S. at 334, this Court should find that Kentucky's AWP law for health insurance carriers does not dictate the choices facing ERISA plans.

Thus, because Kentucky's AWP statute does not directly relate to any employee benefit plan it is not preempted by ERISA.

B. Kentucky's AWP statute does not make sufficient reference to an employee benefit plan to trigger preemption.

Here, the Sixth Circuit found that the "reference to" test was met because:

> under Kentucky's statute, "health benefit plans" were defined to include, among other things, "a self-insured plan or plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA."

Nichols, at 359.

This Court has held that: "Where a State's law acts immediately and exclusively upon ERISA plans, as in *Mackey*, or where the existence of ERISA plans is essential to the law's operation, as in *Greater Washington Bd. of Trade* and *Ingersoll-Rand*, that 'reference' will result in pre-emption." *Dillingham*, 326. Thus, this Court has found the "reference to" provision triggered preemption in

certain cases: *Greater Washington Bd. of Trade*, *supra*, at 130-131 (law that "impos[ed] requirements by reference to [ERISA] covered programs,"; *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 828, n.2, 829-830, (1988) (law that specifically exempted ERISA plans from an otherwise generally applicable garnishment provision); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140 (1990) (common-law cause of action was premised on the existence of an ERISA plan).

The Sixth Circuit's holding ignores the *Dillingham* analysis. The reference to ERISA in Kentucky's AWP statute does not trigger preemption because it does not cause the law to act immediately and exclusively upon ERISA plans, nor is the existence of an ERISA plan essential to the law's operation.

The Sixth Circuit noted but rejected Kentucky's argument that the statute's definition merely restated "the 'deemer clause' by exempting self-insured ERISA plans from the scope of the AWP statute." *Nichols*, at 361. (The 'deemer clause' of ERISA, § 514(b)(2)(B), 29 U.S.C. 1144(b)(2)(B), prevents states from regulating self-insured plans under the guise of regulating insurance. *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990).) The ACLM submits the Sixth Circuit erred by rejecting this argument.

The use of the term "ERISA" in Kentucky's AWP statute does not single out ERISA plans for differing treatment as in *Mackey* or refer to such plans because they are necessary for its operation, as in *Greater Washington Board of Trade*. Rather, it simply acknowledges the limits on the scope of state laws imposed by the deemer clause. Thus, Kentucky's AWP law treats all insurers and all

plans (ERISA and non-ERISA) alike to the extent permitted by federal law. If just the use of the term "ERISA" was, by itself, sufficient to warrant preemption, it would create the perverse result that Kentucky's express acknowledgment of the limits imposed by the deemer clause would render the AWP law preempted. Under that scenario two different states could pass two identical statutes, except that one expressly acknowledged the deemer clause. One statute would be preempted and one would not. The inconsistency of such a result shows that the "reference to" test is not met simply because a statute uses the word "ERISA" somewhere in its text. Otherwise, determining whether a state's statute is preempted by ERISA would be more like searching through an ancient text for a magic talisman instead of engaging in a careful and logical analysis of its history and purpose.

This approach was used by the court in *United Wire, Metal & Mach. Health and Welfare Fund v. Morristown Mem'l Hospital*, 995 F.2d 1179 (3d Cir. 1993). In that case, it was argued that a statute was preempted because it expressly referred to "self funded union plans" as an example of a "third party payor". The court rejected that "magic words" argument, and held that "Where, as here, a reference to an ERISA plan can be excised without altering the legal effect of a statute in any way, we believe the reference should be regarded as without legal consequence for [preemption] purposes." *Id.* at 1192, n.6. Similarly, the court in *Thiokol Corporation, Morton International Inc. v. Roberts*, 76 F.3d 751, 760 (6th Cir. 1996), held that "the underlying purpose of ERISA preemption . . . is to prevent impermissible effects, not references."

Indeed, the District Court in *Community Health Partners, Inc. v. Nichols*, 14 F. Supp. 2d 991 (W.D.Ky. 1998), adopted this analysis:

> In the present case, on the other hand, the existence of employee benefit plans is not *essential* to the operation of Kentucky's AWP law. By definition, the statute applies to the contracts or "plans" by which certain entities assume financial risk for various health-related occurrences. Although ERISA self-insured employee welfare benefit plans and MEWAs are among the risk-bearing entities referenced in the statute, these ERISA plans are by no means the *only* entities affected by the statute. Moreover, although the non-ERISA entities – such as insurance companies and HMOs – defined in the statute primarily contract directly with insured ERISA plans, they also contract with private individuals and groups not affected by ERISA. Thus, it does not meet the requirements of the "reference to" test.

Id. at 996.

The ACLM submits that an ERISA preemption analysis should do more than look for the "magic word". Although Kentucky's AWP statute uses the word ERISA, it only does so to acknowledge the existence of the deemer clause. This statute does not use the term in order to act exclusively upon ERISA plans. Thus, this Court should find that the "reference to" test has not been met.

II. KENTUCKY'S AWP STATUTE IS SAVED FROM PREEMPTION BECAUSE IT REGULATES THE BUSINESS OF INSURANCE IN ORDER TO REGULATE THE PRACTICE OF MEDICINE.

Alternatively, should this Court find that there is preemption, then the Kentucky AWP statute regulates the business of insurance in order to regulate the practice of medicine and thus is saved from ERISA preemption. The AWP statute regulates the business of insurance because it targets "health insurers." Ky. Rev. Stat. Ann. § 304.17A-270. § 304.17A-005(23) defines these entities. The term health insurer includes hybrid organizations composed to arrange and provide health care as well as to insure subscribers for the risk of illness. This Court has stated in *Rush Prudential HMO, Inc. v. Moran*, 122 S. Ct. 2151 (2002) that an HMO " . . . provides health care, and it does so as an insurer" *Id.* at 2160, and that " . . . virtually all commentators on the American health care system describe HMOs as a combination of insurer and provider." *Id.* at 2161. Also, "Nor do we see anything standing in the way of applying the saving clause if we assume that the general state definition of HMO would include a contractor that provides only administrative services for a self-funded plan." *Id.* at 2162. Here, the term health insurer is used interchangeably with the term managed care organization ("MCO"). Managed care organizations include health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs"), exclusive provider organizations, and certain integrated health care delivery systems. See Barry R. Furrow, et al., *Health Law* Sec. 8-1 (1995), Larry J. Pittman, *"Any Willing Provider" Laws and ERISA's Saving Clause: A New Solution For An Old Problem*, 64 Tenn. L. Rev. 409, 412 n.11 (1997).

The AWP statute regulates the business of insurance under the same common sense analysis used in *Rush Prudential*, 122 S. Ct. 2151, 2159-2163. The statute is directed at insurer MCOs and concerns itself with the composition of their physician networks that deliver the care obligations to the patients who are MCO subscribers. It mandates that these health insurers, licensed by and under the regulation of the Respondent, Kentucky Department of Insurance, open up their restrictive physician panels to any Kentucky licensed physician who is willing to meet the terms and conditions of the MCO. The statute does not control these terms and conditions. The statute targets essentially the same entities as the independent review statute in *Rush Prudential*.

The statute also passes the three McCarran-Ferguson tests. First, the statute does target the spreading of risk between the health insurer and the patient insured, although it is not necessary to satisfy this risk-spreading prong to find the statute is saved from preemption. *Rush Prudential*, 122 S. Ct. 2151, 2163. The patient's employer pays a fee to cover the risk of illness in return for the promise of a care obligation. If the patient gets ill, the health insurer then fulfills its care obligation. The care obligation, which is the actual performance of the insurance contract, is inextricably intertwined with the composition of the physician network. This Court has stated, "There can be no doubt that the actual performance of an insurance contract falls within the 'business of insurance,' as we understood that phrase in *Pireno* and *Royal Drug*." *United States Dept. of Treasury v. Fabe*, 508 U.S 491, 503 (1993). Under the AWP statute, the risk of not having the most appropriate doctors in the network for the patient's specific circumstance is reduced and spread to the insurer

who must accept any willing provider. Second, the AWP statute regulates an integral part of the policy relationship between the insurer and the insured, i.e. who will perform the care obligation because patients are basically concerned with which doctors in their MCO network they can choose for their care. The third factor is satisfied based on the analysis in *Rush Prudential*, 122 S. Ct. 2151, 2164. Finally, ACLM agrees with the suggestion that this Court find that state AWP laws avoid preemption if they were enacted for "the purpose of" regulating the business of insurance. Larry J. Pittman, *"Any Willing Provider" Laws And ERISA's Saving Clause: A New Solution For An Old Problem*, 64 Tenn. L. Rev. 409, 496 (1997). Accordingly, the AWP statute regulates the business of insurance.

Moreover, the AWP statute regulates health insurers and their business of insurance in order to regulate the practice of medicine. This statute can increase the number of doctors in the health insurer's network of physicians, which promotes patients having a greater choice of physicians and more access to their preferred physician. This statute also counteracts the scheme of assigning too many patients to any one doctor such that their practice will have an excessive volume of patients. Under the AWP statute patients are more likely to receive the care and attention they require when going to their doctor with health problems. In *Rush Prudential* 122 S. Ct. 2151, this Court concluded: "States regulate insurance in looking out for the welfare of their citizens," *Id.* at 2170 and " . . . regulating insurance tied to what is medically necessary is probably inseparable from enforcing the quintessentially state-law standards of reasonable medical care," *Id.* at 2171. The Court also noted: "Illinois has chosen to regulate insurance as one way to regulate the practice of medicine,

which we have previously held to be permissible under ERISA, see *Metropolitan Life*, 471 U.S., at 741." *Id.* at 2170-71.

A. Kentucky has a legitimate interest under its police powers in regulating the health insurer's restrictive physician membership policy.

The power to regulate the practice of medicine is traditionally reserved to the states through their ability to regulate health care absent clear expressed Congressional intent to the contrary. See *Travelers*, 514 U.S. 645 (1995), *Dillingham*, 519 U.S. 316 (1997), and *Rush Prudential*, 122 S.Ct. 2151 (2002).

States derive their authority to regulate health care from the state police power, which is derived from the Tenth Amendment. See *Jacobson v. Massachusetts*, 197 U.S. 11, 25 (1905). As states can best assess the health needs of their own citizens and enact laws to address those needs, health care is "primarily, and historically, a matter of local concern." *Hillsborough County v. Automated Med. Lab., Inc.*, 471 U.S. 707, 719 (1985). This Court has worked on the assumption that the historic police powers of the States were not to be superseded by ERISA "unless that was the clear and manifest intent of Congress." *Travelers*, 514 U.S. 645, 655 (1995). In *DeBuono v. NYSA-ILA Med. and Clinical Servs. Fund*, 520 U.S. 806, 814 (1997), this Court noted that Congress did not intend for § 514 of ERISA to displace general health care regulation, an area traditionally of local concern. It has also been observed that, "The misuse of ERISA preemption clearly usurps the state's power to protect its citizens." Marilyn Lablaiks, *Bad Medicine: ERISA's Equitable Remedies and*

the Preemption of Fundamental Legal Rights, 34 J. Marshall L. Rev. 583, 609 (Winter 2001).

The AWP statute is a health care regulation, which encompasses the practice of medicine to promote the health and safety of Kentucky's citizens by allowing more physicians to serve a given patient population. This Court has affirmed that: "In the ordinary case, a law will be sustained if it can be said to advance a legitimate government interest, even if the law seems unwise or works to the disadvantage of a particular group, or if the rationale for it seems tenuous." *Romer v. Evans*, 517 U.S. 620, 632 (1996). "But it is for the legislature, not the courts, to balance the advantages and disadvantages of the new requirement." *Williamson v. Lee Optical of Okla., Inc.*, 348 U.S. 483, 487 (1955). Although the Petitioners and their *amici* make several public policy arguments against this statute, the fact is that the Kentucky Legislature is free to make the policy choices it deems best as long as those choices are not legally preempted by ERISA.

The Petitioners' Brief on page 2 claims that: "In exchange for their rate discount, participating providers receive the advantage of access to the HMOs' subscribers and, consequently, increased patient volume over non-network providers who lack such access." Further, "the value of network membership (and, accordingly, the amount providers will agree to discount their services) depends on the HMOs' ability to limit the number of providers in the network; the fewer the providers, the greater the patient volume for each provider."

However, ACLM believes Kentucky has a legitimate interest to regulate the practice of medicine and protect its citizens regarding the number of physicians in an MCO

panel, which relates to the volume of patients in a medical practice. As a matter of common sense, a high volume of patients with discounted professional fees could have a direct effect on the health care that patients receive. The higher volume can make it more difficult for patient's phone calls to get through to their doctors; make it longer to get in for an appointment; and make the patient have to wait longer to get into the examination room. Less time will be available to obtain a complaint, history of present illness, and to acquire or refresh the doctor's knowledge regarding medical history, medications, and allergies. Less time will also be available to conduct an examination, formulate a diagnosis, decide on what tests should be ordered and what treatments should be prescribed. All of these factors obviously impact on the practice of medicine.

Two cases are illustrative of this point. In *Jones v. Chicago HMO Ltd. of Illinois*, 730 N.E.2d 1119 (Ill. 2000), the plaintiff charged the HMO with institutional negligence for negligently assigning the doctor as the child's primary care physician while he was serving an overloaded patient population. The court decided that the HMO owed a duty to refrain from assigning an excessive number of patients to the contract primary care physician. The court noted: "Public policy would not be well served by allowing HMOs to assign an excessive number of patients to a primary care physician and then wash their hands of the matter." *Id.* at 1134. Further, the court recognized that " . . . HMO accountability is needed to counterbalance the HMO goal of cost containment and, where applicable, the inherent drive of an HMO to achieve profits." *Id.*

The second case, *Thomas W. Self, M.D. v. Children's Associated Medical Group* (695870) litigated in San Diego County Superior Court in 1998, also illustrates the

problems that can occur in "high volume – low cost" medical practice. Kathy Kinsey, *Settlement Helps Patch Up Physician's Firing*, Verdicts & Settlements Supplement to the Los Angeles Daily Journal, 1, 4, 8 (June 26, 1998).

In his lawsuit for wrongful termination from a medical group that had a large HMO practice, Dr. Thomas Self alleged that he was terminated because he was spending too much time with his patients. *Id.* at 1. A jury awarded $1.75 million in compensatory damages. *Id.* at 4. Dr. Self was the first doctor to win a case under the California law that prohibits retaliation against doctors for advocating appropriate patient care. *Id.* Spending adequate time with a patient is one example of appropriate patient care that is difficult to do in a high volume practice. Dr. Linda Daniels, chairwoman of the San Diego Medical Society's bioethics committee, stated: "Where health plans are saying you (the doctor) must see six to eight patients an hour, they are setting up a situation where you just can't practice good medicine. Good medicine requires good communication, as well as merely doing an exam or checking a blood pressure. . . . In (just a few) minutes, how in the world are you going to get to know the patient?" Julie Marquis, *Verdict for Doctor in HMO Case Hits Nerve*, Los Angeles Times, A1, A24 (April 15, 1998). In October of 1999, the Journal of Health Politics, Policy and Law published a special issue, *The Managed Care Backlash*. It was noted that one of the reasons for this "backlash" was the widespread public concerns about the effect of managed care on quality and access to care. Mark A. Peterson, *Introduction: Politics, Misperception, or Apropos?*, 24 J. Health Pol., Poly. & Law 876 (1999). Certainly, the citizens of Kentucky, through their legislature, are able to allay these concerns by enacting an AWP law. These examples support the logic that Kentucky has a legitimate interest in

regulating health insurers that are involved in determining the number of physicians who will practice medicine in a given network.

The Petitioner's argument could create the incongruous situation that a state can mandate nurse-to-patient ratios at hospitals but cannot pass AWP statutes to achieve the goal of increasing the doctor-to-patient ratio by trying to provide for a greater number of doctors in MCO panels. California has passed a "Safe Staffing Law" pertaining to hospital nurse-to-patient ratio requirements because of concerns that " . . . quality of patient care is jeopardized because of staffing changes implemented in response to managed care." 30 *J. Law, Med & Ethics* 312 (2002); See Linda H. Aiken, et al., *Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction*, 288(16) J.A.M.A. 1987 (2002). There have been recent reports of patient deaths being linked to nursing shortages, i.e. high patient-to-nurse ratios. Dr. Dennis S. O'Leary, President of the Joint Commission on Accreditation of Healthcare Organizations, stated: "We knew that some unanticipated deaths and permanent loss of function were related to inadequate numbers of nurses, but 24 percent surprised everybody." Sheryl Gay Stolberg, *Patient Deaths Tied to Lack of Nurses*, N.Y. Times, A-18 (August 8, 2002). Although there is no evidence in the record of this case that restrictive physician panels have resulted in patient deaths, ACLM does not believe that Congress intended ERISA to proscribe state laws regulating the supply of doctors while allowing state laws to regulate the supply of nurses.

Opponents of AWP statutes could argue that smaller panels of doctors allow those in the panel to receive more training and experience so as to maintain and improve

their expertise. However, in one case a woman who developed liver cancer was denied coverage to see a surgeon out of network who specialized in liver cancer surgery. Instead, the MCO referred the patient to surgeons who had never performed the specialized surgery and the patient died while fighting the MCO's decision. Elisabeth Rosenthal, *Complications In Care – A Special Report: Patients With Difficult Illnesses Fight New HMO's To Get Help*, N.Y. Times A1 (July 15, 1996). In another case, a patient's parents were forced to go outside the MCO network after the MCO referred her to a surgeon with no experience in treating the type of kidney cancer she had. *Commissioner of Corps. of Cal. v. TakeCare Health Plan, Inc.*, No. 933-0290 (Cal. Dep't of Corps. Oct. 11, 1996). The AWP statute makes it more likely that an insurer's panel would include certain doctors with unique skills and expertise.

Further, even though the Petitioners claim AWP laws infringe upon an MCO's ability to control the quality of the providers, this claim has been refuted. Most MCO's use indirect measures of quality and efficiency, instead of using stringent, objective performance criteria. Robert J. Shouldice, *Introduction to Managed Care* 74 (1991). "But if there were an objectively correct method, every plan should include (or exclude) the same providers. Obviously, the managers of different plans disagree, and none will admit being wrong." Joseph White, *Choice, Trust, and Two Models of Quality*, 24 J. Health Pol., Poly. & Law 996 (1999). The fact that a preferred panel is not assembled based on objective quality measures is a legitimate reason for Kentucky to enact an AWP law, so that consumers are free to make their own judgments about the relative quality of providers.

Thus, the scheme of directing high volumes of patients to limited numbers of doctors in an effort to lower the cost of care and maximize the MCO's profit is subject to state regulation such as the AWP statute because it involves the practice of medicine.

B. Kentucky has a legitimate interest under its police powers in regulating the continuity of care that its citizens receive from their doctors.

"The doctor/patient relationship is an important and special relationship, vital to the provision of health care. It develops over time, by a doctor learning a patient's history and exercising professional judgment in not only evaluating a patient's complaints, but in developing a specific strategy for treating a patient's ailments. Consequently, an individual's choice of doctor is of great importance." *Humana Medical Plan, Inc. v. Ira S. Jacobson, M.D.*, 614 S.2d 520, 522 (Fla. App. 3rd Dist. 1992). Moreover, "when an ailing person selects a physician to treat him, he does so with the full expectation that such physician will do his best to restore him to health, and the contract into which they enter is deserving of more attention from the law than a businessman's expectation of profit from a purely commercial transaction." *Hammonds v. Aetna Casualty & Surety Co.*, 237 F. Supp. 96, 101 (N.D. Ohio 1965).

Patients may change health insurers for a variety of reasons and this may jeopardize the continuity of care, which is important to quality health care. Ezekiel J. Emanuel and Nancy Neveloff Dubler, *Preserving the Physician-Patient Relationship in the Era of Managed Care*, 273 J.A.M.A. 323, 327 (1995). The patient's subsequent health insurer may provide a restricted panel of

doctors, which does not include the patient's original physician, thus fostering discontinuity of care. ACLM submits that patients will more likely retain their doctor of choice under Kentucky's AWP statute if the patient's health insurer changes.

Continuity of care (being under the care of the same physician for health needs) is fundamental to the doctor-patient relationship and has a direct nexus to the practice of medicine. The cornerstone of the practice of medicine is the doctor-patient relationship because doctors cannot practice medicine without patients. See David Orentlicher, *Health Care Reform and the Patient-Physician Relationship*, 5 Health Matrix Journal of Law Medicine 141, 143 (Winter 1995).

Maintaining continuity of care with their usual physician is important to many patients. Margaret M. Love and Arch G. Mainous III, *Commitment to a Regular Physician: How Long Will Patients Wait to See Their Own Physician for Acute Illness?*, 48 The Journal of Family Practice 202 (1999). "Forced disruption of continuity of care is detrimental to patient receipt of primary care, and is a potential negative consequence of annual bidding for managed care contracts." Susan A. Flocke, *The Impact of Insurance Type and Forced Discontinuity on the Delivery of Primary Care*, 45 The Journal of Family Practice 129, 133-134 (1997).

MCO restrictions on physicians who are qualified and willing to meet the terms and conditions of the MCO interfere with the bond between patients and their doctors. Ezekiel J. Emanuel and Nancy Dubler, *Preserving the Physician-Patient Relationship in the Era of Managed*

Care, 273 J.A.M.A. 323, 327 (1995). The selective contracting scheme that the Petitioners advocate and the Commonwealth of Kentucky has reformed may lead to patient dissatisfaction. Christopher B. Forrest, et al., *Managed Care, Primary Care, and the Patient-practitioner Relationship*, 17(4) Journal of General Internal Medicine 270 (2002). Indeed, Jeff Goldsmith, a University of Virginia associate professor and health care industry consultant, spoke at a session on health care in Louisville, Kentucky on August 21, 2002 sponsored by Humana, Inc., the parent company of two of the Petitioners. Patrick Howington, *Rising Costs Means Health-Insurance Change*, Courier-Journal, B1 (August 23, 2002). Goldsmith stated that consumers demand health plans with a wide choice of providers. *Id.* Furthermore, changes in health care systems that promote discontinuity (such as when an employer switches to a plan that a patient's qualified physician cannot join) can be particularly disruptive for patients with chronic diseases, especially asthma. Margaret Love, et al., *Continuity of Care and the Physician-Patient Relationship*, 49 The Journal of Family Practice 998, 1004 (2000).

Indubitably, continuity of care is associated with a higher level of trust between patient and physician. Audiey C. Kao, et al., *Patients' Trust In Their Physicians*, 13 Journal General Internal Medicine 681, 685 (1998) and thus the doctor-patient relationship has been described as a moral covenant between physician and patient. Mark O. Hiepler and Brian C. Dunn, *Irreconcilable Differences: Why The Doctor-Patient Relationship Is Disintegrating At The Hands Of Health Maintenance Organizations And Wall Street*, 25 Pepperdine L. Rev. 597 (1998). There has been widespread agreement that trust between patient

and physician is important for high-quality health care. Arch G. Mainous III, et al., *Continuity of Care and Trust in One's Physician: Evidence from Primary Care in the United States and the United Kingdom*, 33 Family Medicine 22, 27 (2001).

Forced discontinuity caused by insurance changes not only has an impact on patients' quality of care, but can also lead to extra visits and hidden costs. George E. Kikano, et al., *'My Insurance Changed': The Negative Effects of Forced Discontinuity of Care*, Family Practice Management, http://www.aafp.org/fpm/20001100/44myin.html. Preliminary studies suggested that long-standing doctor-patient ties foster less expensive, less intensive medical care. Linda J. Weiss and Jan Blustein, *Faithful Patients: The Effect of Long-Term Physician-Patient Relationships on the Costs and Use of Health Care by Older Americans*, 86 American Journal of Public Health 1742 (1996). Additionally, continuity has been associated with a lower likelihood of future hospitalization, which would lower the cost of care for the MCO. James M. Gill and Arch G. Mainous III, *The Role of Provider Continuity in Preventing Hospitalizations*, 7 Archives of Family Medicine 352, 357 (1998).

Hence, continuity of care is directly linked to the practice of medicine, which Kentucky has the power to regulate. When a patient is forced to a different health insurer that the patient's qualified physician cannot be a part of, even though that physician is willing to meet the terms and conditions of the health insurer, then Kentucky has a legitimate interest in addressing this discontinuity

of care. The AWP statute is a legitimate way for the state to do so.

CONCLUSION

At the end of the day, it should be noted that equally important to the legal analysis which this Court will undertake before arriving at a decision will be application of the analysis, pragmatically, on consumers as patients who seek and who are provided health care and treatment in today's era of health care delivery. Though the tentacles of managed care are embedded within such delivery, the *sine qua non* for quality and timely delivery is not consistent with the views advocated by Petitioners. This case presents, then, yet another foray before this Court (see *Rush Prudential*) to subvert a state's attempt to provide its citizenry with a process that promotes quality, timely and adequate health care. This *amicus* has demonstrated that any willing provider statutes are a mechanism to promote quality medical care by maximizing the number of health care practitioners available to patients within the Commonwealth of Kentucky.

Consequently, Kentucky's AWP statute does not have a relation with ERISA sufficient to invoke preemption; but even if there is a nexus between these state and federal laws here giving birth to preemption, the AWP statute at issue is saved from ERISA's preemptive reach because it (AWP) regulates the business of insurance by regulating the practice of medicine.

WHEREFORE, for all the foregoing reasons, *amicus curiae*, the American College of Legal Medicine, urges this

Court affirm the judgment rendered by the Sixth Circuit Court of Appeals.

Respectfully submitted,

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Kentucky Association of Health Plans, Inc., *et al.*,
Petitioners,

v.

Janie Miller, Commissioner of the
Kentucky Department of Insurance,
Respondent.

On Writ of Certiorari
to the United States Court of Appeals
for the Sixth Circuit

BRIEF *AMICI CURIAE* OF COMMUNITY HEALTH PARTNERS AND RESERVOIR PARK HEALTH SERVICES, INC. D/B/A CENTER CARE

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QUESTION PRESENTED

Whether state Any Willing Provider statutes regulate "insurance" and are therefore saved from preemption by ERISA?

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BRIEF *AMICI CURIAE*

INTEREST OF THE *AMICI*[1]

Amici curiae Community Health Partners and Reservoir Park Health Services, Inc. d/b/a Center Care are the plaintiffs in a parallel challenge to Kentucky's Any Willing Provider ("AWP") statute. *Amici* assemble panels of selected health care providers, including hospitals, and physicians of various specialties, to provide services on a preferred or exclusive basis for managed care entities and traditional insurance companies, as well as for employers that provide health plans but do not carry any form of insurance (so-called "self-insured" or "self-funded" plans). *Amici* brought suit against respondent alleging that the Kentucky AWP statute was preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"). The district court granted respondent summary judgment and the Sixth Circuit affirmed on the basis of its ruling in this case, which it decided the same day. The petition for certiorari filed by *amici* from the Sixth Circuit's decision is pending as 00-1295, *Community Health Partners* v. *Kentucky*.

SUMMARY OF ARGUMENT

I. Any Willing Provider laws have been adopted to protect the interests of politically powerful health care providers that face a loss of their market share under managed care. A major component of the shift from traditional indemnity insurance to managed care has been the increased emphasis on "limited provider networks" – *viz.* discrete groups of providers who offer discounted rates in exchange for guaranteed volumes of patients. The consequence of this trend has been to reduce provider incomes and to exclude less efficient (and

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[1] Petitioners and respondent have filed global consents to the filing of all *amicus* briefs in this case. No counsel for a party authored this brief in whole or in part. No persons or entities other than the *amici* made a monetary contribution to the preparation or submission of this brief.

hence more expensive) providers from a substantial portion of the marketplace. AWP statutes make limited provider networks illegal so as to prevent managed care organizations from securing the economic advantage that comes with the size of their base of policyholders.

II. AWP statutes have neither the form, nor the purpose, nor the effect of regulating "insurance." AWP laws take the form of regulation of the insurer-provider relationship. Their purpose is not to correct any defect in the insurance relationship but instead to preserve market share for certain providers. And they have no effect whatsoever on the insurer-insured relationship, which remains entirely unaffected. AWP statutes are accordingly not saved from preemption by ERISA.

ARGUMENT

I. State Any Willing Provider Statutes Are A Response To The Economic Leverage That Managed Care Organizations Exercise Over Health Care Providers On Behalf Of Their Subscribers.

1. The principal role of traditional indemnity health insurers, like insurers generally, has always been to spread risk. Individuals facing the possibility of needing substantial medical care which could result in crushing expenses turned to a risk pool, which eliminated that prospect in exchange for a fee. The cumulated fees provided the insurers with sufficient revenue to pay their subscribers' medical expenses while covering their own administrative costs and earning a profit.

As health insurance spread widely after World War II (in large part as a result of tax incentives for employers), a substantial diseconomy emerged. For reasons of cost, an uninsured or underinsured individual would avoid unnecessary visits to a medical provider, and the provider would avoid ordering unnecessary procedures. But for individuals with traditional fee-for-service insurance – where the insurer essentially just dispensed money to providers from the pool of

premiums – that important constraint on rising health-care costs was largely missing. Provider fees rose greatly because insurance contracts not only guaranteed providers a certain amount of revenue for each visit and each procedure, but also created little incentive for patients to avoid incurring unnecessary medical expenses. Rather, insured patients had every incentive to seek as much medical care as possible, and doctors had every incentive to provide it. Insurance premiums rose as a result.

Managed care developed largely in response to this phenomenon of health care "overutilization" and the skyrocketing costs of medical care, especially for employer-sponsored health insurance plans. The fundamental premise of managed care is that traditional indemnity insurance, under which the provider was simply reimbursed by the insurer for services rendered, was not economically sustainable because the provider had no incentive to control expenditures. See Matthew K. Wynia, *The Oregon Capitation Initiative*, 276 J.A.M.A. 1441, 1441 (1996) ("[M]any health economists believe that fee-for-service payment of physicians has been a major contributor to the rapid growth in health care costs in the United States."). Among the most common approaches to managed care are reduced-fee-for-service systems and "capitation." "Reduced-fee-for-service" means just what it says – the insurer secures a discounted rate (often substantial) for each visit or procedure. "Capitation" is a per-patient (*i.e.*, per-capita) mechanism: for a set fee, a provider agrees to furnish the insured whatever services are necessary and offered under the plan.[2]

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[2] Paying primary care physicians on a capitated basis achieves the goal of managed care organizations, since "capitation puts the provider at some level of risk or incentive for medical expenses and utilization." Peter R. Kongstvedt, *Compensation of Primary Care Physicians in Managed Health Care*, *in* ESSENTIALS OF MANAGED HEALTH CARE 103, 118 (Peter Kongstvedt ed., 4th ed. 2001). Be-

A principal feature of managed care has been the recognition that insurers can reduce the diseconomy of overutilization by leveraging the purchasing power of their policyholders to obtain better deals from providers, both in terms of lower prices and stricter utilization controls. After all, a large number of patients can have a material effect on a provider's income. Traditional insurance companies nonetheless failed to leverage this economic power because they did not combine the purchasing power of their subscribers. Although policyholders were part of a single risk pool, individuals covered by those policies could spend their insurance benefits with virtually any provider. No particular group of physicians, for example, would know *ex ante* that it would receive the benefit of a large number of patients from any particular insurer. Those physicians accordingly had very little incentive to agree to a reduced fee schedule.

A managed care organization ("MCO") leverages its insurance pool by creating a "limited provider network." Insureds receive services only from this discrete group of providers (unless they pay a higher fee or secure an appropriate referral to go "out of network") and therefore form what is, in effect, a purchasing cartel, through the MCO. The providers in the limited network are guaranteed a certain number (or at least a certain proportion) of the insurer's patient base, accepting lower unit prices in return for higher volume. The providers are accordingly willing to enter into agreements that contrib-

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cause the provider receives a fixed amount per member per month whether she treats the member once or ten times, capitation eliminates the incentive to "overutilize" or over-treat patients that exists in a fee-for-service payment arrangement. Moreover, under capitation, a managed care organization's costs are more predictable, because it knows roughly how much it will have to pay for each member's health care. Capitation is also easier and less costly to administer because there are fewer claims to keep track of and adjudicate than under fee-for-service.

ute to a substantial reduction in health care costs. As reflected in the sworn deposition testimony of a manager of an unrelated MCO in the parallel challenge brought by *amici* against Kentucky's AWP statute:

> [The] bottom line is [that] it's just a very basic business princip[le]. An HMO has contracts and covered lives. They can come to us as a provider network and give us that volume and we take care of them. In exchange for that volume, we provide services for less.

Deposition Testimony of Ronald Derstadt, No. 1:96-CV-202-M, *Community Health Partners, Inc.* v. *Commonwealth of Kentucky* 4 (Sept. 15, 1997). The Kentucky AWP statute is "like a dagger to the heart" of that effort. *Id.* 8.

2. Many providers, particularly those that are less competitive, are understandably hostile as an economic matter to the lower revenues they receive when MCOs create limited provider networks. The economic clout of medical providers is dispersed, and they are accordingly unable to exercise much negotiating leverage to maximize their profits vis-à-vis MCOs. Physicians, for example, generally practice in small groups that serve only a portion of the local population. But unlike insureds, medical providers lack a vehicle through which they can join together to exert a corresponding pressure on MCOs to raise their subscribers' premiums and pay out higher fees. Formal attempts at collective bargaining by providers who lack substantial financial integration would be suspect under the antitrust laws. *See, e.g.*, *Arizona* v. *Maricopa County Med. Soc'y*, 457 U.S. 332 (1982). And any *informal* effort to discourage participation in limited networks is doomed to failure through defections by providers willing to accept the guaranteed revenues offered by MCOs.

a. Providers have accordingly turned to state governments to break up the purchasing power of managed care organizations. Their approach is modeled on the "any willing phar-

macist" legislation enacted in response to the leverage exercised by insurers with respect to prescription drugs. In the 1970s, faced with rising drug costs but seeking to take advantage of the efficiency of larger pharmacies and pharmacy chains, insurers sought to impose caps on pharmacists' profits. Thus, in *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1979), this Court considered a Blue Shield plan under which participating pharmacies accepted a maximum margin of $2 per prescription. Small pharmacies that faced the prospect of losing market share because they could not operate on such thin margins filed suit, alleging that the provider agreement was an unlawful price-fixing agreement and group boycott. This Court rejected the insurer's argument that the agreements were regulated by state law as the "business of insurance" and thus were immune from antitrust scrutiny under the McCarran-Ferguson Act (59 Stat. 34, *as amended*, 61 Stat. 448, 15 U.S.C. 1012(b)).

Insurers faced a substantial difficulty in sustaining the prescription drug purchasing plans of the type at issue in *Royal Drug*. They needed to promise pharmacists a large number of patients to secure, in effect, volume discounts. Not only would high volume justify smaller margins on a per-transaction basis, but those volumes were essential to induce the pharmacies to assume the costs of the plan's administrative requirements (including substantial paperwork). Insurers accordingly created limited pharmacy networks through which plan participants were required to purchase drugs (unless they were willing to pay a higher price).

Smaller, yet politically powerful, pharmacists responded to this expanding threat to their market share by encouraging the adoption of "any willing pharmacy" legislation, which now exists in at least eleven states. See Bureau of National Affairs, Health Law Reporter, *Managed Care: Any Willing Provider Bills Proliferate at the State Level*, Dec. 1, 1994, at 2; Lynn Holladay Avery, *Debate about "Any Willing Provider" Laws Continues in 1995*, 61 Aorn J. 594, 594 (1995)

("Pharmacists traditionally have led efforts to enact any willing provider laws."). These statutes confer two rights: (i) a *pharmacy* has the right to participate in any health insurance network; and (ii) a plan *participant* has the right to use the insurance at any pharmacy he or she chooses. In either event, the pharmacy must be willing to abide by the plan's terms and conditions. See, *e.g.*, 18 Del. Code 7303.

On their face, these "any willing pharmacy" statutes render insurance companies' efforts to create limited networks for pharmacy benefits illegal. The statutes are not, however, intended to expand the number of pharmacists actually participating in limited provider networks. They expressly require each pharmacy to abide by the plans' terms, including reimbursement rates, however low. And, as the *Royal Drug* case illustrated, smaller pharmacies cannot afford to operate at such low margins, particularly when they are not guaranteed large numbers of customers. Rather, the point of the statutes is to break up the purchasing power of insurance companies by depriving any pharmacy of the knowledge *ex ante* that it is guaranteed to receive the high volume that justifies participating and accepting a discounted rate in the first place.

b. The enactment of these statutory schemes was not limited to pharmacies. Politically powerful doctors and other health care providers sought similar legislation – known as "any willing provider" ("AWP") statutes – in resisting the leverage created by the expansion of limited provider networks. Indeed, "[v]irtually every legal scholar who has addressed the issue" regards AWP statutes "as an attempt by politically powerful interest groups in the medical community to protect their current income levels and jobs at the risk of substantially increasing the cost of health care and completely unraveling the optimal combination of cost control and quality that managed care has achieved." James W. Childs, Jr., *You May Be Willing, But Are You Able?: A Critical Analysis of "Any Willing Provider" Legislation*, 27 CUMB. L. REV.

199, 200 (1996-97). The historical record thus demonstrates that AWP statutes represent health care reform "hijacked to serve the economic interests of health care providers who were losing market share, autonomy and income to managed care." David A. Hyman, *Consumer Protection in the Managed Care World: Should Consumers Call 911?*, 43 VILL. L. REV. 409, 412 (1998).

AWP statutes have now been adopted in at least thirteen states; Kentucky's is representative. It prohibits any "health insurer" from excluding "any provider * * * who is willing to meet the terms and conditions for participation established by the health insurer." Ky. Rev. Stat. Ann. 304.17A-270. The statute does not limit the term "health insurers" to traditional insurance companies, but rather includes every conceivable entity that could possibly exercise leverage in health care purchasing (other than an ERISA plan): "any insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky." *Id.* § 304-17A-005(23). And "provider" includes every kind of health care practitioner and pharmacist (including dentists and optometrists). *Id.* § -17A-005(19).

AWP statutes, like "any willing pharmacy" statutes, seek to eliminate the leverage MCOs exercise through limited provider networks. The statutes reduce the purchasing power of the MCOs, and hence their ability to secure reduced fee agreements.[3] The adverse consequences of AWP laws can be

[3] Indeed, AWP statutes make capitation (see *supra* at 3-4 n.2) an economic impossibility for both providers and plans. Without a limited network, providers face the prospect that they will treat too few patients to make the capitation agreement worthwhile. Moreover, a physician who treats only a few patients on a capitated basis runs a higher risk of treating a disproportionate number of insureds who have serious medical problems, the costs of which are not covered by the capitated fee. A larger patient base from the insurance pool ensures that the provider also has a number of clients for whom the cost of care is less than the capitation fee, offsetting the potential costs of insureds needing substantial care. For their part, insurers *require* limited networks to engage in capitation – it is not possible to agree to pay a specialist $50 per patient per year when five, ten, or twenty other specialists may demand to enter the network. The insurer would then be required to pay for the same care many times over.

particularly profound for larger insurers that operate in multiple states. These statutes require plans to establish multiple administrative schemes – for example, one for capitated subscribers outside Kentucky and another for subscribers in that state – and thereby create substantial practical difficulties in the plans' operations. As the Federal Trade Commission has observed, AWP laws "discourage competition among providers, in turn raising prices to consumers and unnecessarily restricting consumer choice in prepaid health care programs, without any substantial public benefit." 00-1295 Pet. App. 101a-02a.

II. Because AWP Statutes Do Not Regulate "Insurance," They Are Not Saved From Preemption By ERISA.

ERISA preempts state laws that "relate to any [covered] employee benefit plan" (29 U.S.C. 1144(a)) but saves from preemption those measures that "regulate[] insurance" (*id.* § 1144(b)(2)(B)). This Court has taken a "common-sense" view of what constitutes insurance (*Rush Prudential HMO, Inc.* v. *Moran*, 122 S. Ct. 2151 (2002)), distinguishing that term from the "business of insurance" and the "business of insurers" (*Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205, 210 (1979)). Thus, an otherwise preempted statute is saved only when "insurers are regulated

with respect to their insurance practices." *Rush Prudential*, 122 S. Ct. at 2159 (emphasis added). The indispensable characteristic of insurance, in turn, is the "spreading and underwriting of a policyholder's risk." *Id.* (quoting *Royal Drug*, 440 U.S. at 211). It is this feature "distinctive to insurance" (*id.* at 2160) that delimits the field that Congress intended to leave to state regulation notwithstanding the consequences to ERISA plans.

1. The focus of this Court's inquiry under the saving clause is the insurer-insured relationship. The statutes that this Court has found encompassed by the clause have not only regulated the insurer-insured relationship (or at least the insurer's management of the assets it receives from policyholder premiums), but have also had the purpose and effect of regulating that relationship.

Most recently, *Rush Prudential* sustained a statute granting plan subscribers the right to an "independent review" of adverse benefits determinations. Previously, *UNUM Life Insurance Co.* v. *Ward* held that California's notice-prejudice rule – under which an insurer must prove prejudice before denying an insured's claim as untimely – constitutes the regulation of insurance, explaining that the test under the saving clause is whether the statute "govern[s] the *insurance relationship* distinctively." 526 U.S. 358, 373 (1999) (emphasis added). Similarly, *FMC Corp.* v. *Holliday* held that Pennsylvania's subrogation rule – which prohibits insurance contracts from providing that payments to insureds will be recouped from tort recoveries – falls within the savings clause because it "controls the terms of insurance contracts." 498 U.S. 52, 61 (1990). And *Metropolitan Life Insurance Co.* v. *Massachusetts* sustained a state law requiring that insurance policies include mental health benefits, explaining that the statute directly "regulates the terms of certain insurance contracts." 471 U.S. 724, 740 (1985).

2. Unlike the statutes previously sustained by this Court under the saving clause, AWP laws have nothing to do with

the insurer-insured relationship, whether in form, purpose *or* effect.

a. As this Court explained in *Rush Prudential*, the "dominant feature" distinguishing managed care organizations from traditional insurers is that MCOs act as a "combination of insurer and provider." 122 S. Ct. at 2161. MCOs thus have not only insurer-insured relationships with their policyholders, but also insurer-provider relationships with those persons and entities from whom policyholders receive services. This combinatorial role does not preclude characterizing MCOs as "insurers" for purposes of the saving clause, for they still spread policyholders' risk. *Id.* at 2162. But neither does it expand the scope of regulation saved to the states under ERISA to encompass, for the first time, state regulation of providers. Instead, this Court must examine at the threshold which of the two MCO roles – insurer or provider – the state is attempting to regulate. If only the latter (as is true of AWP statutes), the state's resort to the saving clause to avoid preemption should fail.

The form of AWP statutes relates not to the insurer-insured relationship, but instead to the insurer-*provider* relationship. The Sixth Circuit frankly conceded that "AWP laws do not change the substantive terms of the insurance coverage." 00-1295 Pet. App. 60a. Indeed, the form of AWP laws is most notable for what the statutes do *not* do. Unlike "any willing pharmacy" statutes (see *supra*), AWP measures do not confer on policyholders a right to visit their personal physicians (or any other provider). Indeed, AWP laws confer no right – whether procedural or substantive – on policyholders at all.

Not only are the limited provider networks regulated by AWP statutes not an "*integral* part of the policy relationship" (*Rush Prudential*, 122 S. Ct. at 2163 (emphasis added)), they are not a part of the policy relationship at all. The Sixth Circuit thus profoundly confused the widespread requirement that managed care participants visit only providers within the

network (unless they receive a referral or pay a surcharge) with the concept of limited provider networks. The former exists whether or not a state has an AWP law. The latter is the method by which MCOs determine the size of their network. Subscribers are generally unaware that their insurer employs a limited provider network.

To be sure, subscribers are aware that their plan permits them to visit only a discrete list of providers and they are similarly aware whether that list includes a physician who previously treated them. But the number and identity of providers are not necessarily or exclusively a function of limited provider networks. Kentucky's AWP law forbids an MCO in that state from formally limiting the size of its network, but the law does not prohibit reimbursement rates that have an identical effect on the number of providers. A Kentucky plan may thus have a very small network because it offers low reimbursement rates that few providers will accept. (Indeed, unable to benefit from the cost savings of limited networks, the plan is quite likely to offer poor reimbursement.)

Thus, MCO participants in Kentucky (which has an AWP law) and Pennsylvania (which does not), may have identical health plans and have access to provider networks that are indistinguishable in size. In both states, it may be equally as likely that a particular individual's doctor participates in the insurer's network. And, in either state, the policyholder is restricted to visiting providers in the network.

It is no answer that, as a formal matter, the AWP statute appears in the Kentucky Insurance Code. Contra 00-1295 Pet. App. 23a. States easily could have taken the alternative approach of forbidding providers from joining limited provider networks rather than forbidding insurers from forming such networks. But that alternative approach would plainly be preempted on the ground that such a restriction on provider participation "relates to" ERISA health benefit plans. In an effort to take advantage of ERISA's saving clause, states accordingly imposed the regulation on the insurer and codified

the AWP restriction in their insurance codes. But the inescapable fact remains that regulation of insurer-provider relationships is *not* a traditional subject of insurance regulation that Congress can be said to have intended to reserve to the states in the saving clause. The Kentucky Department of Insurance thus candidly acknowledged in its official response to an inquiry by the Kentucky Optometric Association regarding the effect of the state's AWP statute: "In the past, the Department has had very little involvement in the relationship between a provider and the insurer/HMO."[4]

Nor is it an answer that the Kentucky AWP statute formally applies to all "insurers" (defined very broadly). Traditional indemnity insurers, long the subject of state insurance regulation, are nominally included within the statute's scope, but are essentially unaffected by it because they lack the direct provider relationships of MCOs. Conversely, entities that have *no* insurer-insured relationship and thus that do not spread risk at all – *e.g.*, MCOs acting merely as administrators for non-ERISA plans – *are* directly regulated and heavily affected by the statute. AWP statutes are thus targeted at every entity that conceivably could, on behalf of its subscribers, exercise economic leverage against providers, without regard to whether those entities are engaging in traditional "insurance practices."

b. AWP laws similarly do not have the *purpose* of regulating the insurer-insured relationship. To the contrary, neither Kentucky nor any of the other states in the litigation over AWP statutes has yet been able to identify a defect in the insurance relationship that states are seeking to correct. In-

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[4] Letter from Commissioner George Nichols III to Darlene W. Eakin, Executive Director, Kentucky Optometric Ass'n 1 (Feb. 7, 1997). This letter is an official record of the State of which this Court may take judicial notice, and was also produced by respondent in discovery in the parallel litigation brought by *amici* challenging the Kentucky AWP statute.

stead, the statutes' transparent purpose is to eliminate the purchasing power of the insurance pool and thereby to preserve the market share and profit margins of those less efficient providers that would lose out under managed care.

But the regulation of insurer-provider relationships, including regulation directed at the competitive consequences of insurers' conduct on providers, is not the regulation of "insurance." That is the holding of *Royal Drug*, which concluded that the "business of insurance" does not encompass agreements between an insurer and its providers. Provider agreements, the Court explained, can be said to involve the "business of insurance *companies*," but they do not involve "insurance," a term of art that describes spreading and underwriting risk. 440 U.S. at 211 (emphasis added). Indeed, the Court made quite clear that its holding extended to exclusive provider agreements indistinguishable from those addressed by AWP statutes, as when "an insurance company entered into a contract with a large retail drug chain whereby its policyholders could obtain drugs under their policies *only from stores operated by this chain*." *Id.* at 215 n.12 (emphasis added).

Royal Drug explains that provider contracts do not constitute "the spreading and underwriting of a policyholder's risk" through the policy. 440 U.S. at 211. The Court thus distinguished between "the *obligations* of [an insurer] under its insurance policies, which insure against the risk that policyholders will be unable to pay * * * and the *agreements* between the [insurer] and the participating [providers], which serve only to minimize the costs [the insurer] incurs in fulfilling its underwriting obligations." *Id.* at 213 (emphasis added). Provider agreements also are not integral to the insured-insurer relationship or limited to entities in the insurance industry. *Id.* at 216. Instead, they constitute "separate contractual arrangements" between the insurer and providers, the latter of whom are "engaged in the sale and distribution of

goods and services other than insurance." *Id.* That reasoning applies fully to this case.

The Sixth Circuit nonetheless held in this case that state "insurance" regulation includes restrictions on provider contracts. On that view, in states that approve limited provider networks, the McCarran-Ferguson Act protects even the most extraordinary monopolistic and predatory limited provider networks from federal antitrust scrutiny. There is no reason to believe that Congress intended to carve such a substantial hole out of the fabric of federal regulation.

c. Finally, AWP statutes do not have the *effect* of regulating the insurer-insured relationship. It is common ground that AWP statutes do not affect the risk underwritten by the insurer, for the terms and conditions of insurance policies – and thus the risk transferred – remain absolutely identical under AWP laws. The Sixth Circuit nonetheless opined that AWP statutes have the effect of spreading the "risk" that a policyholder will not be able to receive care under the terms of the plan from a participating provider of her choice. 00-1295 Pet. App. 60a. That is simply not correct.

AWP do not confer on policyholders the right to visit their personal physician or even to have their physician admitted to the network. That choice rests with the provider, who may be entirely unwilling to accept the plan's reimbursement rates and other conditions, and who (in the considerable experience of *amici*) will *not* go to the trouble of joining an insurance network in order to be able to treat a particular patient. Nor do AWP laws mandate larger provider networks such that a policyholder's physician will be incrementally more likely to be a member of the network.

In any event, the Sixth Circuit's conception of "risk" is simply another way of saying that AWP statutes can potentially benefit insureds. There is no evidence that AWP statutes actually benefit policyholders, but there is not even a suggestion that they do so in a way that relates to the "risk"

that is "spread" or "underwritten" by the insurance contract as this Court's precedents require. *Royal Drug* thus specifically found with respect to provider networks that while "[s]uch cost-savings arrangements may well be sound business practice, and may well inure ultimately to the benefit of policyholders in the form of lower premiums * * * they are *not* the 'business of insurance.'" *Id.* at 214 (emphasis added). It made no difference that policyholders were affected by the provider agreement in *Royal Drug* itself, which, although it may not have directly "restrict[ed] the number of providers in question" (00-1295 Pet. App. 62a), offered such a small reimbursement that numerous pharmacists could not afford to participate (see *Royal Drug*, 440 U.S. at 209 ("only pharmacies that can afford to distribute prescription drugs for less than this $2 markup can profitably participate in the plan")).

As Judge Kennedy explained in her dissent in this case, "any concerns over freedom of choice are beside the point. The critical issue with respect to the risk spreading prong, as well as whether the law regulates insurance as a matter of common sense, is whether or not the law is related to the risks underwritten by the insurer." 00-1295 Pet. App. 84a. AWP laws lack that critical relationship and are accordingly preempted by ERISA.[5]

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[5] There would be no merit to the argument that AWP laws benefit insureds or the employers that finance their coverage. "[M]anaged care has expanded health insurance coverage options available to consumers" by providing them access to coverage at lower costs. Richard I. Smith et al., *Examining Common Assertions About Managed Care*, *in* ESSENTIALS OF MANAGED HEALTH CARE, *supra*, 71, 72. Recent studies have found that HMOs, for example, reduce the use of services by 20% compared to traditional health plans, leading to a cost savings ranging from 20% to 40%. Kenneth E. Thorpe, *Health Care Cost Containment: Reflections and Future Directions*, *in* JONAS & KOVNER'S HEALTH CARE DELIVERY IN THE UNITED STATES 439, 452 (Anthony R. Kovner and Steven Jonas, eds., 6th ed. 1999). As a result of this cost savings, managed

care organizations have become more attractive to employers seeking to provide health care coverage for their employees. See Peter D. Fox, *An Overview of Managed Care*, *in* ESSENTIALS OF MANAGED HEALTH CARE, *supra*, 3, 3 (as of 1999, HMO enrollment had reached 81.3 million, with preferred provider organization ("PPO") enrollment not far behind). The further movement of workers into managed care plans, in turn, "has generated impressive reductions in private-sector health care spending." *Id.* 466. Spending by employers on health insurance, which increased at an average annual rate of 11.3% between 1985 and 1990, declined to 6.8% during the late 1990s. *Id.* 467.

The effect of AWP laws is to drive more cost-effective managed care organizations from the market. A 1998 Barents Group LLC study commissioned by the American Association of Health Plans found that AWP laws would increase costs for HMOs by thirteen to sixteen percent, and would increase costs for all managed care health plans by between 6.6% and 8.6%. ESSENTIALS OF MANAGED HEALTH CARE, *supra*, at 799. A similar study by Arthur Andersen & Co. commissioned by the Florida legislature concluded that enactment of proposed AWP legislation in Florida would increase per-member, per-month costs of private-sector managed care plans by approximately 15%. *Id.* See Fred J. Hellinger, *The Expanding Scope of State Legislation*, 276 J.A.M.A. 1065 (1996) (citing studies indicating that any willing provider laws "increase the cost of care"); Holladay Avery , *supra*, at 597 (citing studies); Fred Hellinger, *Any-Willing-Provider and Freedom-Of-Choice Laws: An Economic Assessment*, 14 Health Aff. 297, 300 (1995) ("[I]mplementation of an AWP law * * * would increase the administrative costs of the typical managed care organization by 43 percent."). Indeed, both the Federal Trade Commission and the National Governors Association have repeatedly reaffirmed their opposition to AWP laws, on the ground that such laws have the "effect of denying consumers the advantages of cost-reducing arrangements and limiting their choices in the provision of health care services." *Id.*

CONCLUSION

Amici respectfully suggest that the judgment of the Sixth Circuit should be reversed.

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